Lesbian, Gay, Bisexual, Transgender Health & Wellness Profile

County of Riverside Department of Public Health

2014

Table of Contents

Forewords **3**

Executive Summary **7**

Acknowledgements **9**

External Review Panel **10**

Introduction **11**

Demographic Profile of the LGBT Community **15**

Health Behaviors **26**

- Substance Use (i.e., Tobacco, Alcohol, and Other Drug Use) 27
- Eating Disorders, Obesity and Associated Risk Behaviors 34
- Sexual Risk Behaviors and Family Planning 38
- Summary 41

Health Conditions **42**

- Chronic Disease 43
- Communicable Disease 54
- Summary 65

Health Care Access **66**

- Summary 73

Mental Health **74**

- Social Support and Perceived Social Acceptance 75
- Psychological Distress 77
- Suicide 79
- Summary 82

Violence, Assault and Harassment **83**

- School Based Violence, Assault and Harassment 84
- Hate Crimes 87
- Sexual Assault and Intimate Partner Violence 88
- Summary 91

Table of Contents

Recommendations **92**

Appendices **94**

Glossary 95

Technical Notes 98

Resources 99

Bibliography **100**

Foreword

The LGBT community has historically been poorly or incompletely evaluated by many social service agencies, including public health departments. Complicated by a lack of hard data and unique social concerns, a full and objective assessment of this community's health concerns and disparities is desperately needed.

As in previous assessments, we have more questions than answers. Yet it is important to keep asking these questions for a diverse community now representing 3.5 percent of the American population. In Riverside County, where our LGBT community in the eastern county is the third largest by size in the United States, the issue is even more critical.

It is incumbent upon all of us to ensure that health disparities and inequities are studied and understood, and strategies to counter them are implemented. For a community that has lacked such a detailed analysis in the past, it is our hope that this document will provide a useful basis for further exploration.

Cameron Kaiser, MD
Public Health Officer
County of Riverside

Foreword

Historically, the field of public health has fostered a greater understanding of the consequences of unclean water, unvaccinated citizens, and the dangers of poorly refrigerated foods. Public Health has brought us the benefits of fluoridated water, the use of seat belts for all motor vehicle passengers, and a decrease in deaths from coronary heart disease and stroke. The positive impact on the health of society cannot be overemphasized. Yet there is still more to accomplish, more depths to mine for a greater understanding of how to promote a healthier and stronger society. LGBT health and wellness is one of those areas. Although healthcare disparities and outcomes have long been described in the literature within the LGBT community compared to the hetero-sexual community, we have not attended to the details.

The *Lesbian, Gay, and Bisexual, Transgender Health and Wellness Profile from the County of Riverside Department of Public Health* attempts to sift these details, providing an awareness of striking health disparities. For example, there is a disproportionately high rate of smoking among gay and lesbian youth. Gay and lesbian teens smoke at a rate twice that of their heterosexual peers. In another disturbing finding, we learn bisexual woman report intimate partner violence at a rate nearly three times that of their heterosexual female peers. Such results are frightening and disturbing. Yet, where are we discussing and seeking solutions to this scourge? Are these disparities even known?

Ignoring the above, some may ask why there is need for such a specific report. How is the health of the LGBT community that different from the larger community? Wasn't the goal of the gay civil rights era one of inclusion and the belief that all humans are equal and the same? Statistics above should be sufficient to demand the attention to the details of the health disparities of the LGBT community, but read the full report to find additional startling statistics. When we attend to the details of this endeavor, as seen in this report, startlingly disturbing results are unearthed.

It has been my pleasure to meet and work with the County of Riverside Department of Public Health: a hardworking and compassionate ensemble. So in conclusion, it is my esteemed honor to present to the reader a first of its kind: *The Lesbian, Gay and Bisexual, Transgender Health and Wellness Profile from the County of Riverside Department of Public Health*. May this report herald a call to action.

Charles Gonzales, MD
Assistant Clinical Professor
Family Medicine
University of California at Riverside

Foreword

Despite recent advances in equality, lesbian, gay, bisexual and transgender people (LGBT), continue to face discrimination based on sexual orientation and/or gender identity. Social stigmatization, harassment, and prejudice lead to disparities in health. As a result of these chronic stressors, many LGBT people struggle with depression, anxiety, low self-esteem, substance abuse and suicidal thoughts.

The LGBT Health and Wellness Profile sheds new light on the troubling issue and provides important information about the LGBT population at the national, state, and local level. This report provides one of the first comprehensive compilations of research studies on LGBT health. The participants represent individuals from diverse walks of life. This historic new window into the health and lives of LGBT youth and adults in the Inland Empire, California, and the United States advances our knowledge and leads us to ask new questions for future research. When we better understand the risks and resiliencies regarding a myriad of health issues facing LGBT people, we can better address unmet health needs. It can also help guide decisions on where to better direct scarce financial resources.

The Riverside County Department of Public Health has gathered meaningful data that can help us better assist our local LGBT population. For the first time, disparate research on LGBT people has been united into one comprehensive document that can help set priorities for our communities' health and mental wellness needs. Baseline data and health outcomes can be more easily measured and compared to future research. This document opens the door to government funding for all the organizations that work with our community and need easy access to this data.

The information provided in this important publication will be invaluable to local LGBT community agencies, like The Center, which are seeking funding to provide culturally appropriate mental health services to our local LGBT community. It will also serve as an important tool for healthcare organizations to assist them in understanding how they can be a resource for this historically underserved population.

I am honored by the opportunity to contribute to the *LGBT Health and Wellness Profile*. I hope this report is found useful by researchers and academics, as well as by service providers who work to improve LGBT lives every day.

Jill Gover, Ph.D.
Director of Counseling
The LGBT Community Center of the Desert

Foreword

Recent months have seen unprecedented success in the mission to achieve legal and social equality for the LGBT community. Despite these great strides in social policy, our friends and neighbors who identify as either lesbian, gay, bisexual or transgender face unique challenges when it comes to their health.

While some disparities like higher rates of HIV and smoking have been previously identified through research, newer data on increased rates of intimate partner violence are just now being explored within the LGBT population. So much is still unknown, and each new exploration leads to new questions that deserve thoughtful answers. How do we characterize the needs of this growing community if we are not asking the right questions?

The Desert AIDS Project, as one of the largest HIV/AIDS services providers in Riverside County, is proud to be a contributor to The LGBT Health and Wellness Profile. We see this report as the beginning of a badly needed conversation. It's an opportunity for community members from all backgrounds to understand each other better.

With better data comes better advocacy. All humans, regardless of their color, creed, or sexual/ gender identity, deserve the chance to live happy and healthy lives. We believe it is our collective responsibility to ensure that no group fall through the cracks.

I'm proud of the collaboration and work that went into this groundbreaking report and look forward to the fruitful discussions and actions that will come from it.

David Brinkman, MBA
Chief Executive Officer
Desert AIDS Project

Executive Summary

Introduction

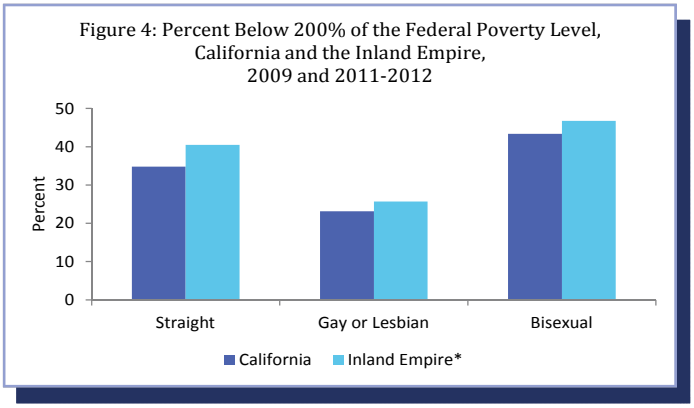
The collection and use of data is fundamental to ensuring an equitable distribution of public health resources and the development and provision of accessible health care programs. Data on the health status and health care needs of the lesbian, gay, bisexual, and transgender (LGBT) community is severely lacking. What data is available suggests that the LGBT community experiences disproportionately poor health outcomes. The lack of data collection on sexual orientation and gender identity makes it difficult to establish the extent of these health disparities as well as the factors that contribute to these health disparities.

Using the few data sources that are available, this report aims to shed light on what is currently known about the health status of Riverside County's LGBT community. The report explores significant gaps in LGBT health data and services so that county agencies and local non-profit organizations can collaborate to close those gaps and work toward reaching health equity.

Demographics

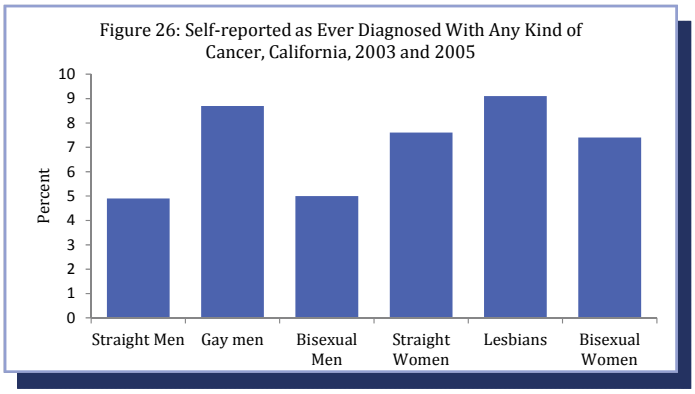
Lesbian, gay and bisexual residents comprise 4.2% of the population and transgender residence between 0.1—0.3% making Riverside County one of the largest LGBT communities per capita in the nation.

Contrary to national indicators, Riverside County gay men and lesbians report the highest levels of education and income. Bisexuals report the lowest incomes and education levels of the three groups.

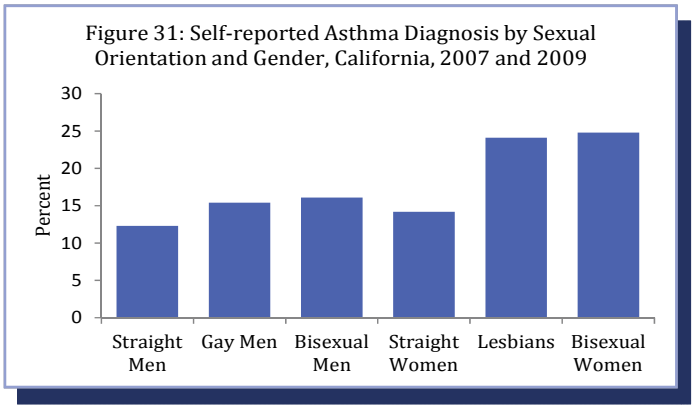


Risk Behaviors & Health Conditions

Certain behaviors have been found to increase risks for chronic disease and premature death. These risk factors include excessive alcohol consumption, use of tobacco, poor dietary practices, physical inactivity, and high-risk sexual behaviors. All behaviors which occur at higher rates within the LGBT population.



In California, nearly 1 in 10 lesbians (9.1%), and gay men (8.7%) self-report a cancer diagnosis and nearly a quarter of all lesbians (24.1%) and bisexual women (24.8%) report having an asthma diagnosis. Two conditions that are linked to the higher prevalence of risk factors in the LGBT population.

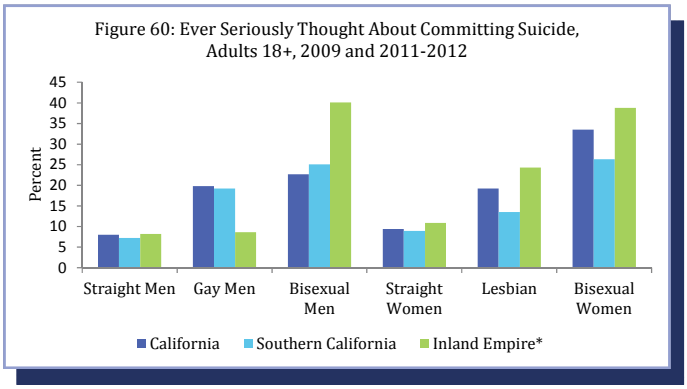


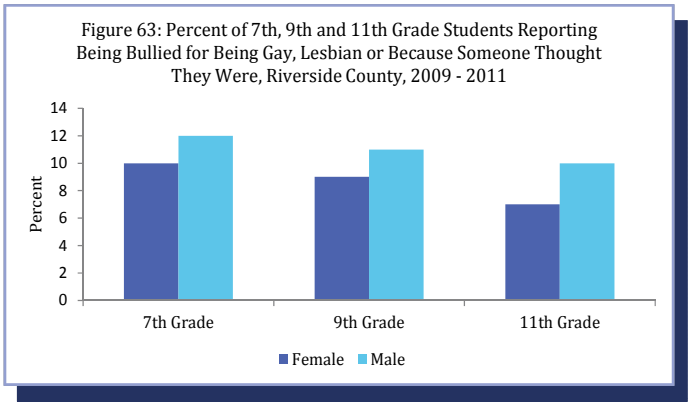
Mental Health & Violence

Violence and fear of violence can lead to negative health outcomes and exacerbate or even create health disparities. An increased risk for many health and social outcomes exists for those who are victims of abuse. These outcomes can lead to anxiety, substance use, depression, suicidal ideation, low self-esteem, chronic health conditions, academic failure, incarceration and poverty.

In Riverside County, approximately 9% of girls and 11% of boys in 7th, 9th, and 10th grade reported being harassed or bullied for being gay, lesbian or because someone thought they were.

In California, two to four times more lesbian, gay and bisexual adults report having seriously thought about suicide than heterosexuals.





Acknowledgement

This report was prepared by
Aaron T. Gardner, M.A.
Research Specialist
Epidemiology & Program Evaluation
County of Riverside Department of Public Health

Contributors

Erin Curlee, B.S.
Research Analyst
Epidemiology & Program Evaluation

Wayne R. Harris, JD
Administrative Services Supervisor
Office of Vital Records

Wendy Hetherington, MPH
Public Health Program Chief
Epidemiology & Program Evaluation

Cameron Kaiser, MD
Riverside County Public Health Officer
Department of Public Health

Rick Lopez, B.S.
Research Specialist
Epidemiology & Program Evaluation

Kevin Meconis, MPH
Epidemiologist
Epidemiology & Program Evaluation

Danyte Mockus, Ph.D., MPH
Epidemiologist
Epidemiology & Program Evaluation

Marshare Penny, DrPHc., MPH
Epidemiologist
Epidemiology & Program Evaluation

Katy Preciado, MPHc
Intern
Calif./Nevada Public Health Training Center

County of Riverside, Department of Public Health staff and interns who reviewed and provided additional feedback on early drafts of this report include: Jose Arballo Jr., Consuela Edmond, Susan Harrington, Sarah S. Mack, Dianne Orr, Michael Osur, Vanessa A. Quintana, Salomeh Wagaw

Please use the following citation when referencing this report:

County of Riverside, Department of Public Health. *Lesbian, Gay, Bisexual and Transgender Health and Wellness Profile, 2014.*

We appreciate any questions or comments that you may have about this report and welcome recommendations for improving subsequent reports. If you have any comments to share please contact us at:

Epidemiology and Program Evaluation
County of Riverside, Department of Public Health
4065 County Circle Drive, STE 211
Riverside, CA 92503

or electronically through our website at:
www.rivcohealthdata.org

External Review Panel

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The intent of this independent review was to provide candid and critical comments that would assist the County of Riverside, Department of Public Health in making this report as sound and useful as possible.

- David Brinkman, MBA, Chief Executive Officer, Desert AIDS Project
- Charles D. Gonzales, M.D., Assistant Clinical Professor, University of California, Riverside
- Jill Gover, PhD., Director of Counseling and Wellness Programs, The LGBT Community Center of the Desert
- Margaret Hawkins, MPH, CHES, Program Manager, Master of Public Health Program, School of Community & Global Health, Claremont Graduate University
- Ryan Quist, Ph.D., Deputy Director, County of Riverside Department of Mental Health
- The Rev. Benita Ramsey, Board President, Rainbow Pride Youth Alliance
- Peggy Roa, Board President, Jeffery Owens Community Center
- Jamie Rotnofsky, Ph.D., CRC, QME, CP, Director, County of Riverside Employee Assistance Services
- Nancy Jean Tubbs, M.S., Director, LGBT Resource Center, University of California, Riverside

Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the report nor did they see the final draft of the report before its release.

Introduction

Why this report?

Riverside County has one of the largest LGBT populations in the country (Gates, 2006; Gates & Cooke, 2011). Members of the lesbian, gay, bisexual and transgender (LGBT) community are our neighbors, co-workers, friends and family and they experience disproportionately poor health outcomes and poor health status.

Despite progress gained in equality for LGBT people over the last four decades, national data suggest that members of the LGBT population continue to experience poorer health outcomes than their heterosexual counterparts (Harcourt, 2006). To understand these health disparities it is important to look at the social determinants of health. Social determinants of health are the economic and social conditions under which people live, work and play that affect their health (U.S. Department of Health and Human Services, 2009; Centers for Disease Control and Prevention, 2012a; Lick et al., 2013).

Stress from societal stigmatization, systematic harassment and discrimination, and a lack of cultural competency in the health care system place LGBT people at higher risk for violence and illnesses such as cancer, mental illness, and other diseases. They are more likely to smoke, drink alcohol, use illicit drugs, and engage in other risky behaviors (Table A). We cannot estimate the full extent of LGBT disparities due to a lack of data collection on sexual orientation and gender identity at national, state, and local levels (IOM, 2011; Lick et al., 2013).

Using national, state and local data sources, this report aims to shed light on what is currently known about the health status of Riverside County's LGBT community. The report explores where there are significant gaps in LGBT health data and services so that county agencies and local non-profit organizations can collaborate to close those gaps and work toward reaching health equity.

Table A: Social/behavioral Factors & Health Concerns Relevant to LGBT Populations

Prejudice & Discrimination	Cultural Factors	Disclosure of Sexual Orientation, Gender Identity	Concealed Sexual Identity
• Provider bias, lack of sensitivity • Harassment and discrimination in medical encounters, employment, housing and child custody • Limited access to care or insurance coverage • Pathologizing of gender-variant behavior • Violence against LGBT populations	• Body culture: eating disorders • Socialization through bars, drug, alcohol, and tobacco use • Nulliparity (no pregnancies): breast cancer • Parenting: insemination questions, mental health concerns • Gender polarity in dominant culture: conflicts for transgender persons	• Psychological adjustment, depression, anxiety, suicide • Conflicts with family of origin, lack of social support • Physical/economic dislocation	• Reluctance to seek preventive care • Delayed medical treatment • Incomplete medical history (e.g., concealed risks, sexually related complications, social factors)

Adapted from Dean et al, 2000, page 105

People who are both LGBT and members of a racial or ethnic minority may often face greater health disparities. As the National Coalition for LGBT Health (2009) notes, "a black gay man faces disparities common to the African-American community as well as those suffered by the LGBT community, and a transgender Spanish-speaking woman, regardless of her sexual orientation, must navigate multiple instances of discrimination based on language, ethnicity, and gender." By improving our understanding of the health needs and values of the LGBT community the public health system can design interventions and prevention programs which are welcoming, culturally competent and more effective (Mayer et al., 2008; Meyer, 2001; Center for American Progress, 2012).

To achieve health equity we need an understanding of the current health status of all Riverside County residents. When it comes to LGBT health, we know a lot about some issues (HIV and gay men) and very little about other health issues affecting LGBT populations. Local data collection is a key step to increasing our knowledge and understanding of issues affecting the LGBT community. One example of a local data collection effort is a recent needs assessment of Palm Springs area residents conducted by The Center (September, 2013). Its online convenience sample of mostly older (80% over 50 years old), white (90%), gay (71%), and educated (70% had a 4-year degree or higher) individuals is an important step in understanding the unique regional needs of Riverside County's diverse LGBT community. The assessment, though not representative of the larger Riverside County LGBT community, had many findings similar to those reported here. Those similarities include high rates of alcohol and other substance use, overweight and obesity, unprotected sex, intimate partner violence, chronic illness, depression, anxiety and suicidal ideation. This report has compiled the current state of local data on LGBT health issues highlighting both what we know and areas where we need further research.

The mission and goals of the County of Riverside Department of Public health remains in-line with the four overarching national goals of Healthy People 2020, which are to:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

This report is one of many steps the Department of Public Health is taking to promote and protect the health of all County residents and visitors in service of the well-being of the entire community.

Who are LGBT people, and how do they self-identify?

It is important to be explicit in what is meant by LGBT people or the LGBT community. The acronym LGBT refers to Lesbian, Gay, Bisexual, and Transgender. Although all of the different identities within "LGBT" are often grouped together (and share the commonality of discrimination based on sexism), there are specific needs and concerns related to each identity.

Defined as "not exclusively heterosexual" lesbians, gay men, and bisexual men and women (LGB) include people who openly identify as LGB, among other terms, and those who don't use such labels but experience same-sex attraction or engage in same-sex sexual behavior. LGB people come from every culture, ethnicity, education and income level, health status, and lifestyle (IOM 2011 page 12; Meyer 2001).

Transgender people are defined according to their gender identity and presentation, not their sexual orientation. Transgender people are individuals whose gender identity differs significantly from what is traditionally associated with their birth sex. Transgender individuals can have different sexual orientations (IOM 2011, page 12; Mayer, et al., 2008). Though the experiences of transgender persons are substantially different from cis-gender (gender-conforming) lesbians, gay males, or bisexual women and men, they are subject to many of the same discriminatory practices, harassment, and violence, as lesbians, gay men, and bisexual men and women. Further, fear of rejection by family and friends makes the "coming out" process similar for all these groups (Hughes & Eliason, 2002).

Notes on Reading this Report

- **A glossary of common terms relating to LGBT populations can be found in the appendix.**
- **Throughout this report the terms "heterosexual" and "straight" are used interchangeably.**
- **Throughout the publication the asterisk symbol (*) is used to denote when some or all of the lesbian, gay or bisexual rates are unstable. For information on rate instability please see the technical notes in the appendix.**

Demographic Profile

How large is the LGBT population?

Defining a population by sexual orientation or gender identity is complex. Within the lesbian, gay, bisexual or transgender (LGBT) population, there is diversity in culture, ethnicity, education, income, health status, and lifestyle. Though challenging, estimating the size and composition of the LGBT population is a critical first step to inform public health policy and research.

Documentation of LGBT demographics is limited and estimates vary for many reasons including different definitions of whom to include in the population, differences in research methodologies and lack of consistency in questions on surveys over time. However, there are various estimates that place the size of the lesbian, gay, and bisexual (LGB) population of the United States between 3% and 10%, with most recent estimates near 3.5% for the U.S. and 4% in California (Gates, 2011; Gates & Newport, 2012; Gates & Newport, 2013). A recent report by the National Center for Health Statistics (Chandra et al., 2011) estimates that 11% of women and 6% of men between the ages of 15 – 44 report having had at least one same-sex sexual experience regardless of sexual orientation. The California Health Interview Survey (CHIS), a household-based random sample survey, estimates the LGB adult population of Riverside County to be 4.2% (CHIS 2011— 2012). These numbers likely underestimate the true size of the LGBT population due to reluctance of some to identify as gay, lesbian or bisexual to an interviewer or on a survey and the exclusion of transgender respondents (IOM, 2011; Meyer & Northridge, 2007). Using the range of 3 -10% would place the LGB population of Riverside County from a low of 70,747 to as high as 235,822 individuals (Table B).

Table B: Estimated Gay, Lesbian and Bisexual Population of Riverside County by Age Group and Race/ethnicity, 2011

	12 – 17 Years		18 – 59 Years		60 + Years		Total	
	3%	10%	3%	10%	3%	10%	3%	10%
White	2,425	8,082	17,119	57,062	6,542	21,807	26,085	86,951
Hispanic	3,213	10,709	31,839	106,131	2,087	6,958	37,139	123,798
Asian	263	877	2,392	7,974	484	1,614	3,139	10,465
African American	476	1,585	2,210	7,368	513	1,709	3,199	10,662
American Indian	35	117	233	776	60	199	328	1,092
Pacific Islander	11	35	74	246	18	59	102	339
Multi-race	132	441	497	1,658	125	32,761	754	2,515
Total	6,555	21,846	54,364	181,215	9,828	65,107	70,747	235,822

There are no national or local data available on the total number of transgender people; thus, these estimates undercount the full LGBT population. According to reports published by the National Gay and Lesbian Task Force and The Williams Institute some organizations and researchers have speculated that 0.1 – 0.3% of the US population is transgender (Cahill, South, & Spade, 2000; Gates, 2011). Using these estimates, the transgender population of Riverside County would be between 2,358 to 7,075 individuals. It is important to note that transgender people exhibit the full range of sexual orientations, from homosexual to bisexual and heterosexual. Table C illustrates respondents reported sexual identities on the National Transgender Discrimination Survey (Grant et al., 2010).

Table C: Transgender Respondents by Self-reported Sexual Orientation, National Transgender Discrimination Survey, 2010.

Sexual Orientation	Percent Of Respondents
Gay/Lesbian/Same-gender	23%
Bisexual	25%
Queer	23%
Heterosexual	23%
Asexual	4%
Other	2%

In 2006, Gates ranked the country's congressional districts by the estimated percent of adults who are gay, lesbian or bisexual. At that time (109th Congress), California's 45th Congressional District located in Riverside County (now the 36th Congressional District – Raul Ruiz) was ranked fifth in percent of the adult population and third highest by size of the total LGB population throughout the United States (Gates, 2006). Other Inland Empire Congressional districts more closely matched the national average percent of LGB adults in the United States.

LGBT Families

According to 2010 US Census data, there are an estimated 7,237 same-sex couples living in Riverside County (Table D). This equates to 10.55 same-sex couples per 1,000 households, making Riverside County the fifth-highest ranked county in California for same-sex couples and 33rd among all 3,033 U.S. counties (Gates, & Cooke, 2011).

Among cities, Palm Springs, California is ranked first in the state and third in the nation with 2,440 same-sex couples (Table E).

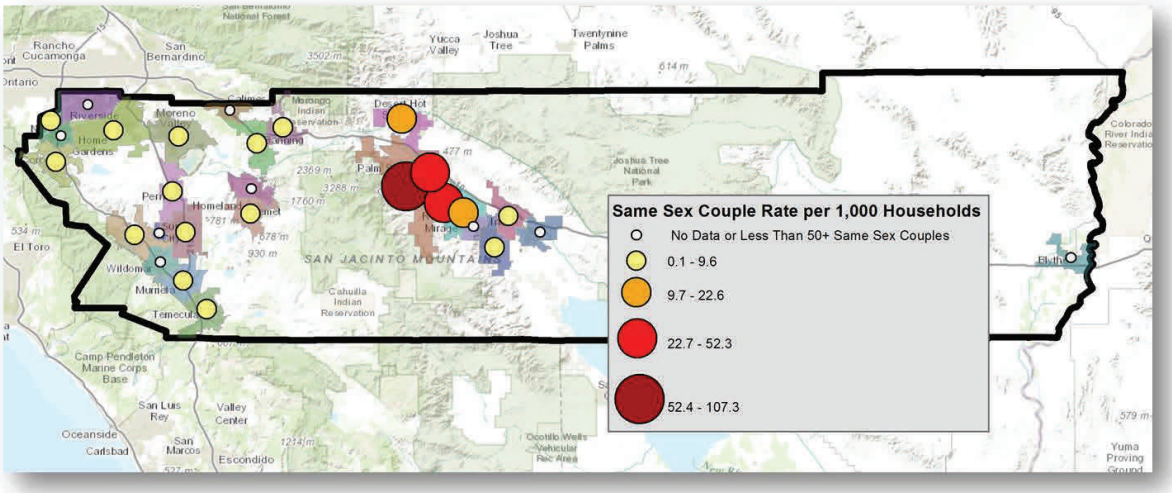
Table D: Count of same sex-couples by year and geography, 2008-2010

Region	2008	2009	2010
Riverside County	5,181	6,232	7,237
San Bernardino County	1,742	2,011	3,016
California	84,404	81,954	98,153
United States	564,751	581,300	646,464

Table E: Cities Ranked by Same-sex Couples per 1,000 Households, 2010 Census Cities with 50+ Same-sex Couples

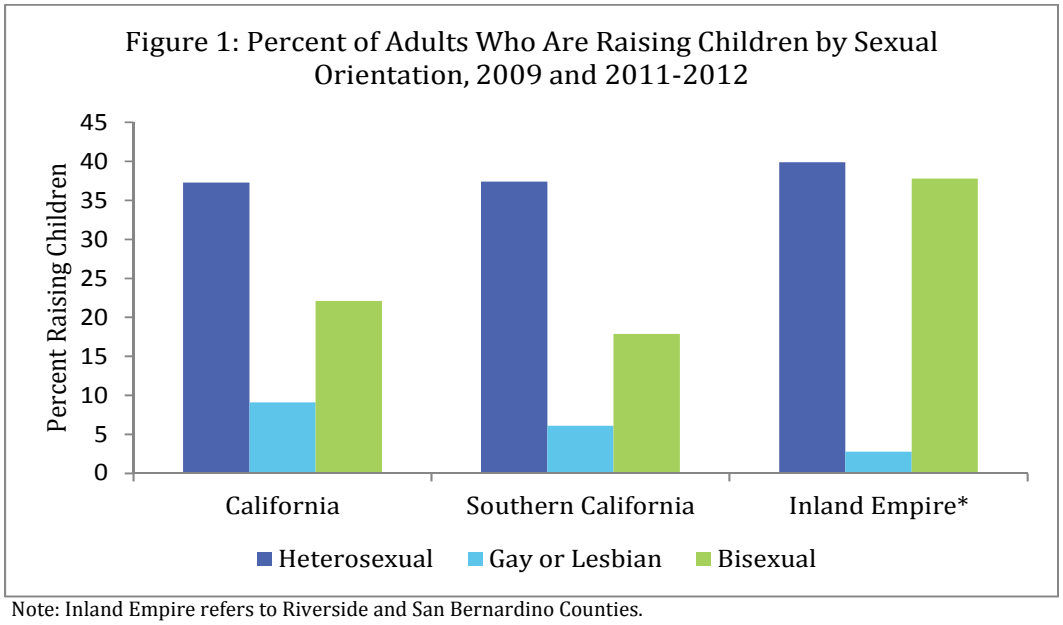
State Rank	US Rank among 1,415 cities with 50+ same-sex couples	City	Same-sex Couples	Same-sex couples per 1,000 households
1	3	Palm Springs	2,440	107.28
4	8	Rancho Mirage	462	52.29
5	11	Cathedral City	790	46.33
10	42	Desert Hot Springs	195	22.56
20	86	Palm Desert	334	14.47
43	219	La Quinta	142	9.56
86	465	Indio	165	7.05
100	557	Lake Elsinore	96	6.52
111	648	Beaumont	72	6.13
123	740	Riverside	526	5.72
155	934	Banning	53	4.86
156	937	Hemet	146	4.85
171	1014	Eastvale	62	4.53
186	1077	Moreno Valley	224	4.35
192	1116	Perris	69	4.22
206	1187	Menifee	108	3.95
230	1306	Corona	153	3.40
250	1394	Murrieta	86	2.64
251	1394	Temecula	81	2.56

Gates, & Cooke, 2011



Members of the LGBT community are also parents. A joint 2007 study conducted by the Williams Institute and The Urban Institute found that nationally "more than one in three lesbians have given birth and one in six gay men have fathered or adopted a child" (Gates et al., 2007). Data provided by the California Health Interview Survey (Figure 1) show that statewide 9.1% of lesbians and gay men and 22.1% of bisexuals are raising children under 18 years of age (CHIS 2009 and 2011-2012).

Data is not available for the number of transgender men and women raising children.



Note: Inland Empire refers to Riverside and San Bernardino Counties.
*Gay, lesbian and bisexual Inland Empire rates are unstable, refer to technical notes section for details.

Nationally, 2012 Gallup poll results show that nearly one-third (32%) of all women regardless of sexual orientation or gender identity are raising children under age 18 in the home. However, differences in child rearing were seen among men, with heterosexual men about twice as likely as gay or bisexual men to have children in the home (16% vs. 31%) (Gates & Newport, 2012).

Note: Throughout the publication the asterisk symbol (*) is used to denote lesbian, gay or bisexual rates that are unstable and should be read with caution.

Employment and Education

Gallup poll data (Gates, & Newport, 2012) shows that nationwide, LGBT as a group have lower levels of education and income than their heterosexual counterparts. The opposite appears true in Riverside County and California. Throughout California, gay men and lesbians generally have higher levels of education than their heterosexual or bisexual peers (Table F). Unfortunately neither California nor Riverside County data on education attainment or employment for the transgender community was available.

Table F: Educational Attainment for Population Aged 25 and Older, California, CHIS 2009 and 2011-2012

Highest Educational Level Completed	Heterosexual	Gay or lesbian	Bisexual
Less than High School Diploma	15.9	5.7	11.4
High School graduate	24.8	17.4	22.6
Some College	14.8	15.8	21.0
Vocational/Associate's Degree	9.8	9.7	11.2
Bachelor's Degree	22.5	27.0	22.2
Graduate Degree	12.2	24.4	11.6

Table G: Percent of Transgender Respondents by Education Attained, National Transgender Discrimination Survey, 2010.

Highest Educational Level Completed	Transgender
Less than High School Diploma	4.1
High School graduate	8.4
Some College	27.6
Vocational/AA/AS	12.7
BA/BS	27.2
Graduate Degree	20.0

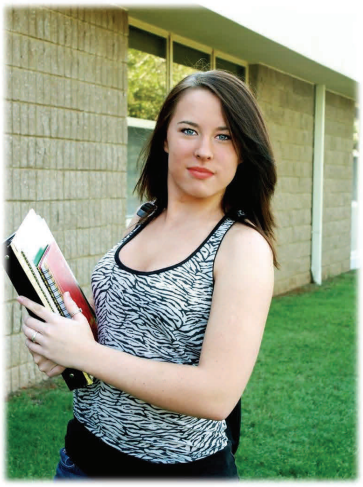
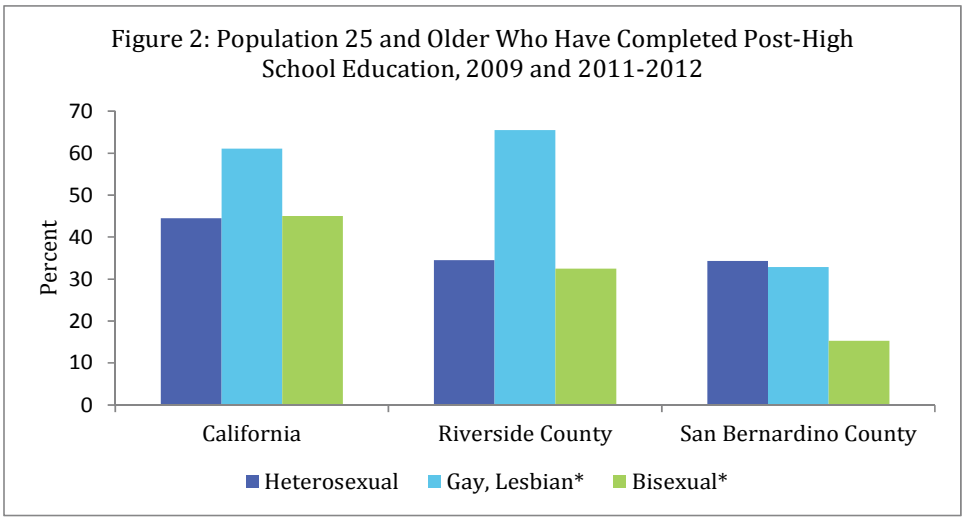


Image Courtesy of Stockvault.net

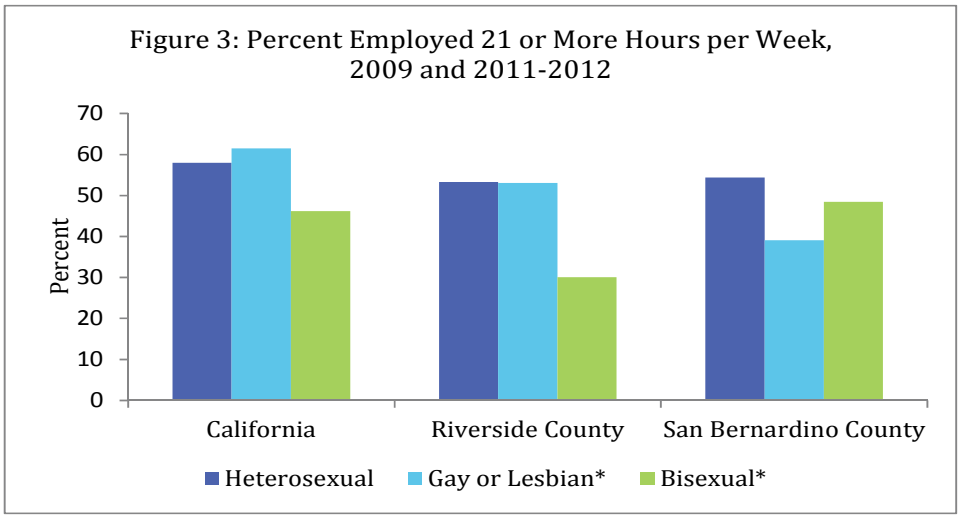
Nationally, 28% of the general population over the age of 25 has a bachelor's degree or higher (ACS, 2010). In California it is estimated that 51.4% of gay men or lesbian women aged 25 and older has attained at least a bachelor's degree, compared to 34.7% for heterosexuals and 33.8% bisexuals. In Riverside County, it is estimated that 56.9% of gay men or lesbian women aged 25 and older has attained at least a bachelor's degree, compared to 22.1% for heterosexuals (CHIS, 2009 and 2011-2012). Data for the Riverside County bisexual community is not stable enough for reporting.

As for the transgender population on the national level, 47% have completed at least a bachelor's degree (Table G).

In Riverside County it is estimated that 66% of the gay and lesbian population 25 and older has completed post high school education compared to 35% for heterosexuals and 33% for bisexuals (Figure 2).



*Riverside County bisexual and San Bernardino County lesbian, gay and bisexual rates unstable. Transgender data unavailable



*Riverside County bisexual and San Bernardino County lesbian and gay rates unstable. Transgender data unavailable

In California and Riverside County, gay men, lesbians and heterosexuals are more likely to be employed full-time (21 or more hours per week) than their bisexual peers (Figure 3).

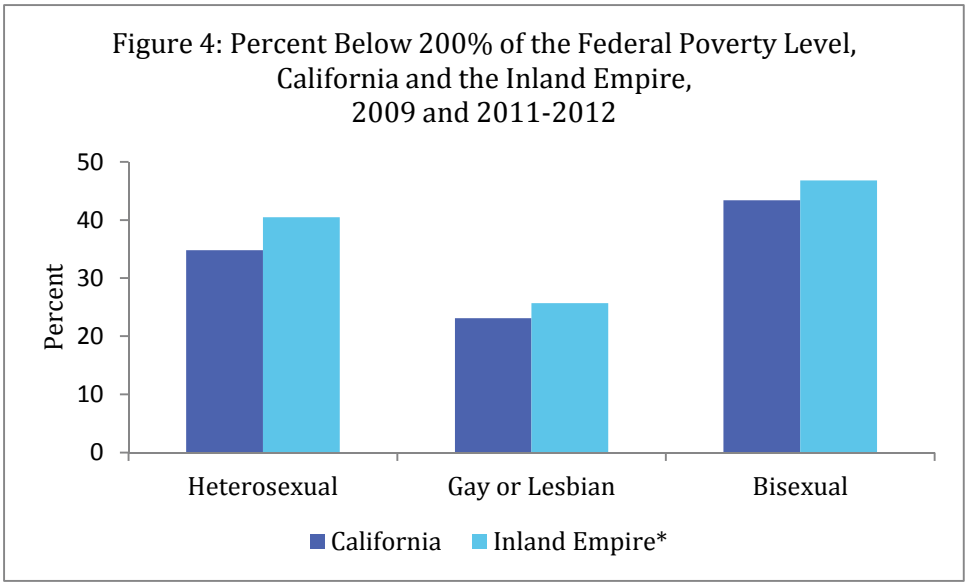
For respondents to the National Transgender Discrimination Survey (Grant et al., 2011), the unemployment rate for transgender individuals was double that of the general population during the same time period (14% vs. 7%).

In summary, those who identify as lesbian or gay maintain higher employment rates and better education levels; however, this does not appear to hold true for those who identify as bisexual or transgender.

Income and Poverty

What is the federal poverty level? Poverty thresholds are the original version of the federal poverty measure, and are updated each year by the Census Bureau. According to the 2010 poverty thresholds, a single individual under 65 years old with an annual household income of $11,334 or less is considered at or below 100% of the federal poverty level. An income for an individual at or below 200% of the poverty level would be $22,688 or less. A family of four with an annual household income of $22,314 or less is considered at or below 100% of the federal poverty level.

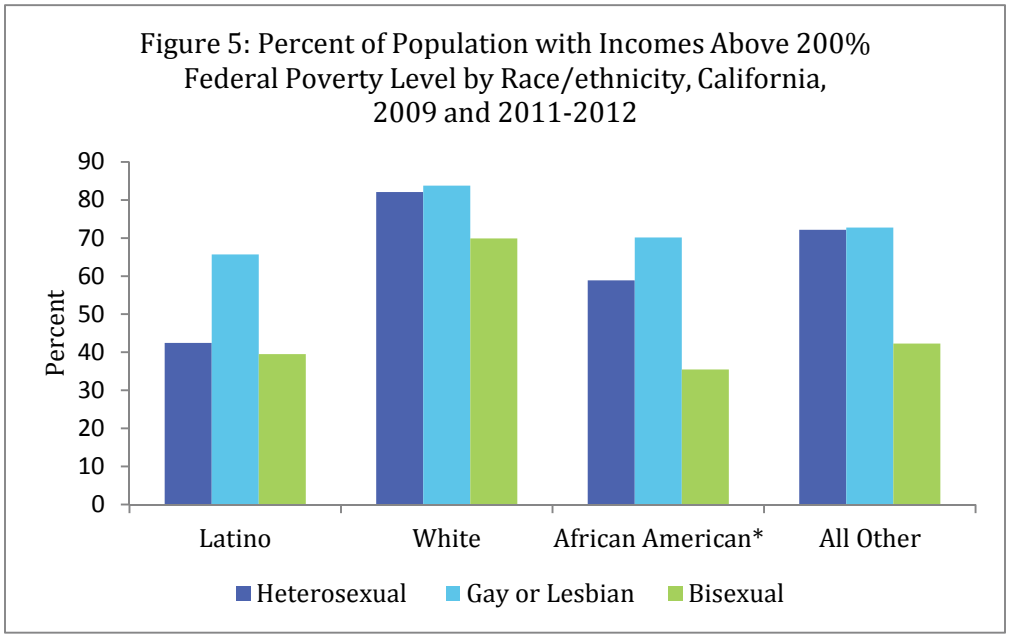
Most national surveys comparing poverty among LGB and heterosexual adults show lesbians, gay men and bisexual men and women experience higher rates of poverty than their heterosexual peers (Badgett et al, 2013). In California and the Inland Empire (Figure 4) poverty rates for gay men and lesbians are lower than their heterosexual counterparts, though 46.8% of bisexuals in the Inland Empire live at or below 200% of the federal poverty line. Statewide, 23.1% of gay men and lesbians and 43.4% of bisexuals live at or below 200% federal poverty level. This is compared to straight/heterosexual men and women in California, where 34.8% live below 200% of the federal poverty line statewide and 40.2% in Riverside County (CHIS 2009 and 2011-2012).



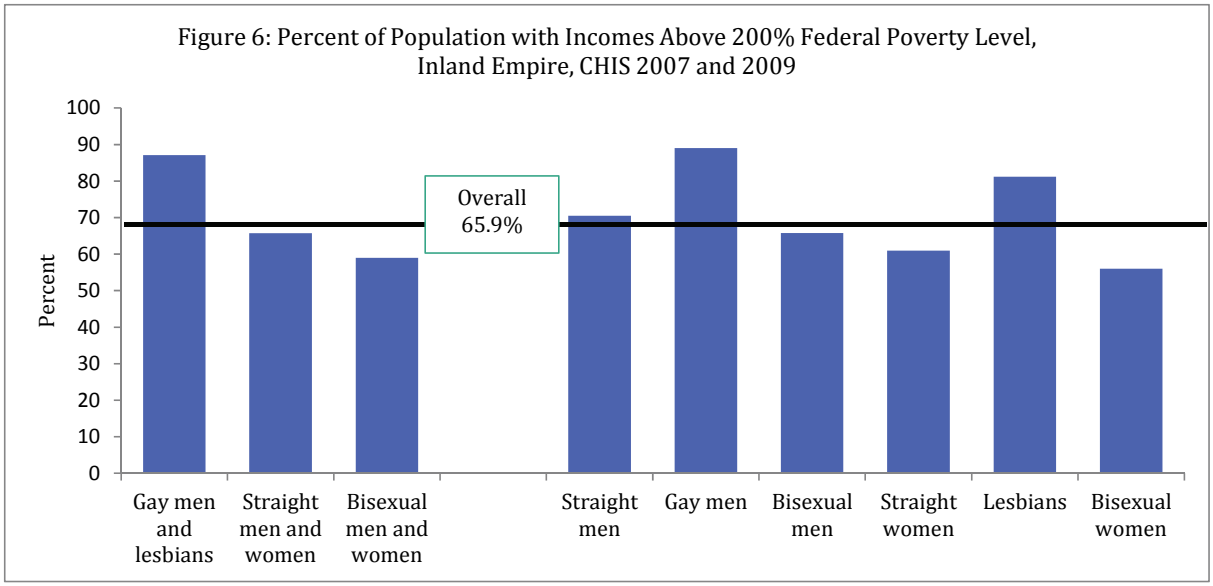
Transgender data unavailable

When looking at the intersection of racial and ethnic minority status and sexual orientation, data shows that lesbians, gay men and bisexuals who are also racial minorities earn less than their white counterparts. In terms of income, bisexuals fare far worse, making less than their hetero-sexual or gay/lesbian counterparts across all racial and ethnic groups (Figure 5).

Though local data was unavailable, among respondents to the largest national survey of transgender individuals, 30% reported incomes below 200% of the poverty level (Grant, et al., 2011).



*African American lesbian, gay and bisexual rates unstable.

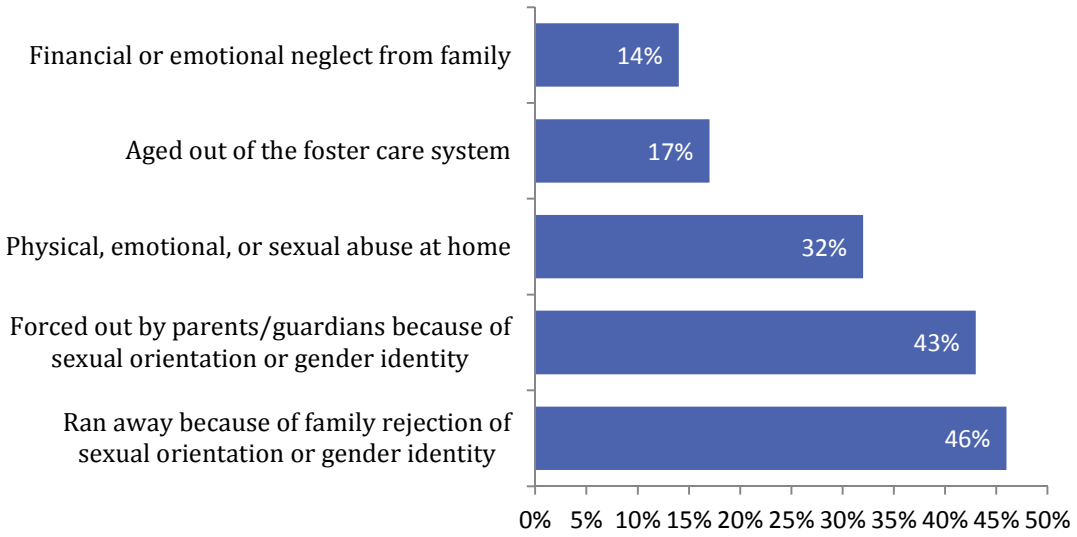


Homelessness

Homeless youth (children and young adults under age 24) are at a significantly increased risk of engaging in harmful coping behaviors (e.g. survival sex, drug use, theft) and experiencing direct health threats such as physical and sexual abuse, HIV or sexually transmitted diseases (STDs). These same youth face increased barriers to care due to legal issues of young age and lack of identification. Of the estimated 575,000 – 1.6 million unaccompanied homeless youth in the U.S. between 20% and 40% are LGBT (Durso & Gates, 2012; Corliss et al, 2011; Rice et al, 2012; Garofalo & Bush 2008).

In a recent national survey of 354 agencies providing services to homeless youth (Durso & Gates, 2012) almost all reported serving LGBT youth. These same agencies reported that family rejection and being forced out of the family home because of the youths' LGBT status as the chief factors contributing to LGBT homelessness (Figure 7). These agencies indicated that nearly seven in ten (68%) of their LGBT homeless clients experienced family rejection and over half (54%) experienced abuse in their family (Durso & Gates, 2012).

Figure 7: Top Five Reasons LGBT Youth Are Homeless or At-risk for Becoming Homeless



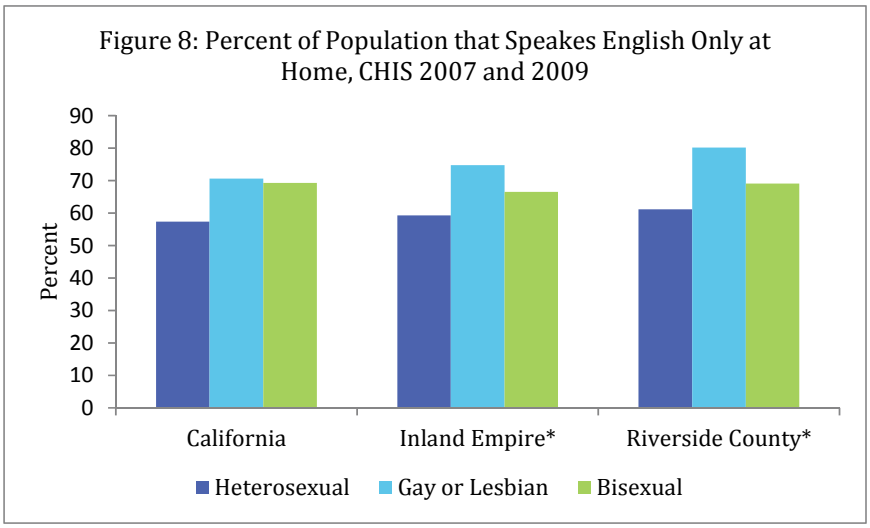
Adapted from: Durso & Gates, 2012

For the first time this year, the San Francisco Human Services Agency began asking survey respondents to their annual point-in-time homeless census about sexual orientation. They found that 29% of the homeless respondents identified as LGBT, a rate nearly double the estimated total LGBT population of San Francisco (San Francisco Chronicle, June 22, 2013).

Questions about sexual orientation and gender identity are not asked in the Riverside County point-in-time homeless census. In total, there are an estimated 10,398 homeless individuals living in Riverside County. An estimated 7% (728) are under 24 years old (2011 County of Riverside Homeless Count & Survey).

Language Spoken at Home

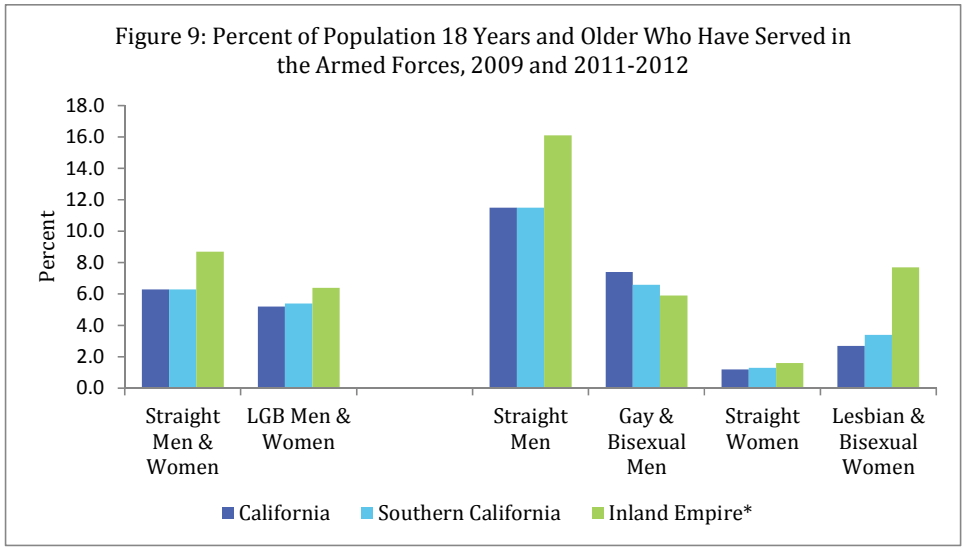
Self-identified lesbians, gay men and bisexual men and women are more likely to speak English at home than their heterosexual counter-parts. Transgender data was unavailable.



Military Service

Fewer lesbian, gay and bisexual Californians report having ever served on active duty in the U.S. armed forces (CHIS, 2009). This is not surprising given the historical ban on LGBT people serving in the military. This ban was lifted for lesbian, gay and bisexual service members in September of 2011, but transgender persons continue to be banned from military service (Miller, 2012).

Notably, 20% of respondents to the National Transgender Discrimination Survey served or are serving in armed services (Grant, et al., 2011). In comparison, 9.9% of the general population of the United States has served in the armed service (2006-2010 American Community Survey 5-Year Estimates).



Historic enforcement of the ban on military service and the Defense of Marriage Act has reduced access to veterans' benefits such as health coverage, higher education, and mortgage assistance for LGBT Americans (GAO, 2004).

Summary

Demographics are ways to measure the characteristics of a population and helps in examining trends and determining needs for a community. Monitoring demographic indicators is critical in understanding the social, economic, educational, and cultural diversity that impacts pubic health planning.

- Riverside County has one of the largest LGBT populations per capita in the nation. Estimates place the size of the Riverside County lesbian, gay and bisexual (LGB) population between 70,747 - 235,822 people. The most recent population based survey places the (LGB) population at 4.2% of the general population or over 92,000 individuals. The transgender population of Riverside County is estimated to be between 2,358 and 7,075 individuals.
- There are an estimated 7,237 same-sex couples living in Riverside County. City rankings of the number of same-sex couples per 1,000 households place Palm Springs (107.28 per 1,000 households) as highest in the state and third highest in the nation.
- More than 9% of gay and lesbian and over 22% bisexual Californians are raising children.
- Gay men and lesbians in Riverside County report higher levels of education than heterosexuals while bisexuals report the lowest.
- Gay men and lesbians in California and Riverside County report the lowest levels of poverty of any sexual orientation while bisexuals report the highest levels.
- Riverside County heterosexuals, lesbians, and gay men report working 21 or more hours per week at nearly the same rate. Although the county rate for bisexuals is unstable, the trend is similar to California overall with bisexuals having the lowest employment rates.
- Local demographic information on the transgender population is nearly nonexistent due to a lack of data collection.

Health Behaviors

Health behaviors are actions taken by a person to maintain good health and prevent illness. Examples of positive health behaviors include not smoking, eating healthy, regular exercise, and limiting alcohol consumption. Health behaviors are more than personal choices. They are strongly influenced by the social and physical environments in which we live, work and play. Discrimination, minority stress, income, geography, education and social support are among many social determinants of health playing significant roles in health behaviors and the "personal choices" available. In fact, one of the four overarching goals of Healthy People 2020 is "to create social and physical environments that promote good health for all" (USDHHS, 2009).

Identification of differences in health behaviors in LGBT communities compared with the general population is fundamental to developing and evaluating interventions that are designed to reduce health and health care disparities adversely affecting LGBT people. Also, improved understanding of protective factors such as increased physical activity among gay men and higher resilience to stress among LGBT populations can help improve health outcomes.

Decades of research has shown that, depending on the sub-group, the LGBT community has increased rates of smoking, drug use, binge drinking, obesity, and eating disorders (Conron, Mimiaga & Landers, 2010). In this section, we will focus on these health behaviors using the available data from across the nation, the state and locally.

Images Courtesy of Stockvault.net

Substance use (tobacco, alcohol, and other drug use)

LGBT populations are subject to the same health and social consequences of substance abuse as are women and men in the general population.

Despite many gaps in the research on substance abuse and sexual orientation, recent data suggest that substance use among lesbians and gay men—particularly alcohol use—has declined over the past two decades while heavy and binge drinking among the general population as increased slightly. However, according to the Centers for Disease Control and Prevention, LGBT individuals are more likely to use drugs and alcohol, have higher rates of substance abuse, are less likely to abstain from alcohol and drug use and are more likely to continue heavy drinking into later life compared to their heterosexual and cis-gender counterparts (www.cdc.gov; Hughes & Eliason 2002).

There are many possible reasons why substance abuse is high among LGBT populations. As mentioned by Greenwood and Gruskin (2007), it has long been hypothesized that the high tobacco, alcohol and other drug use rates among LGBT populations is facilitated by the importance of bars and nightclubs which historically have provided safe spaces to congregate, socialize, and find acceptance and support. Additionally, the tobacco and alcohol industry support the LGBT population through direct advertisement and sponsorship of promotional events. Furthermore, given the stigma associated with sexual or gender minority status, alcohol and other drugs may be used by both men and women to lower inhibitions associated with same-sex social and sexual activities (Greenwood & Gruskin 2007).

Images Courtesy of Stockvault.net

Tobacco

National Picture

The adverse health effects of smoking include numerous cancers, cardiovascular disease, cerebrovascular disease, coronary heart disease, respiratory disease, reproductive effects (fertility, low birth weight), cataracts, diminished health, hip fractures, low bone density, and peptic ulcer disease. The tobacco industry has openly targeted the LGBT community since 1992 when cigarette adds began appearing in *Genre* magazine (Goebel, 1994). Tobacco industry advertising has also used community outreach and event sponsorships to promote tobacco use among LGBT persons (Goebel, 1994).

For the past three decades, lesbian, gay and bisexual smoking rates are significantly higher than the general population. Studies on smoking rates of gay men and lesbians typically show 30-50% higher smoking rates for gay men over heterosexual men and up to 70% higher for lesbians over heterosexual women. The highest smoking rates appear to be among bisexuals with smoking rates between 69% and 114% above that of the general population (Gruskin, et al., 2007; Greenwood & Gruskin 2007; American Lung Association, 2010; Conron, et al., 2010). Recent data indicates the same may be true for transgender populations (Table I). In one large sample of transgender individuals, trans-men smoked 43% more than men in general and trans-women smoked 58% more than the general population of women (Grant, et al. 2011). Studies focusing on LGBT youth (Table H) found similar results with lesbian, gay and bisexual youth using tobacco at much higher rates than heterosexual youth (MMWR, 2011; Coker, et al 2010).

Table H: Smoking Rates Among Students in Grades 9-12 (CDC-MMWR, 2011a)

Heterosexual Youth	Gay & Lesbian Youth	Bisexual Youth
18.9%	35.4%	39.6%

Transgender data unavailable

Table I: Percent of Smokers by LGBT Status from National Samples.

	General Population	Gay Men and Lesbians	Bisexual	Transgender Men and Women
Men	25.4%	22.3% – 30.9%	34.2% – 39.1%	33%
Women	20.7%			29%

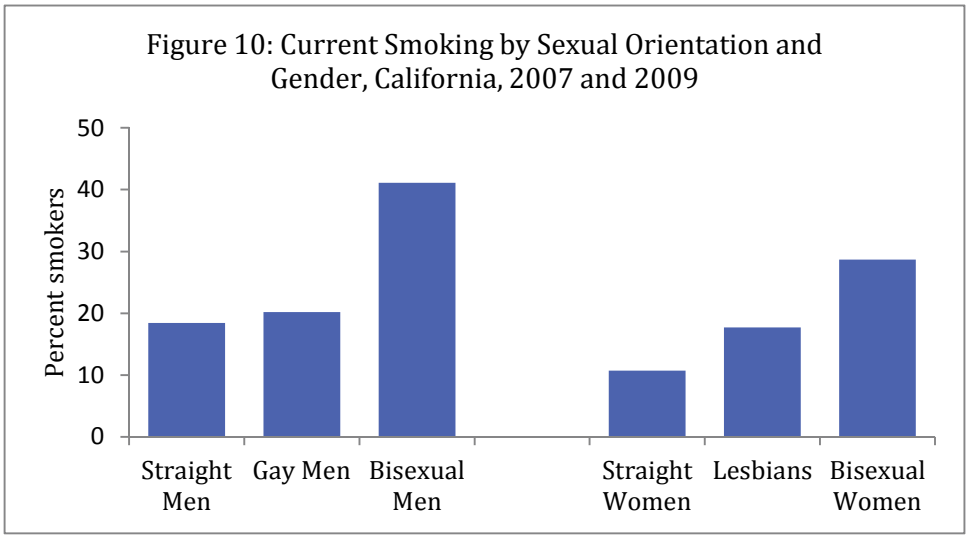
General population: 12 years and older SAMHSA 2011; Transgender Men and Women: Grant et al 2011.

Tobacco ads appearing in LGBT publications (from American Lung Association, *Smoking Out a Deadly Threat: Tobacco Use in the LGBT Community*, 2010).

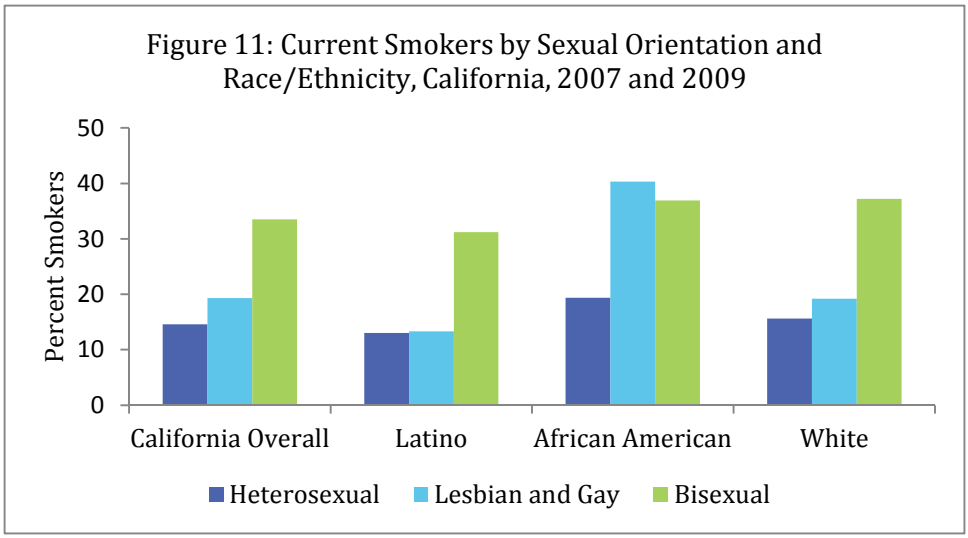
Local Picture

Since January 1, 1995, smoking has been banned in all enclosed workplaces in California, including restaurants and bars (bars were excluded until January 1, 1998) which has eliminated one of the ways smoking has been facilitated in the LGBT community. Despite the smoking ban in bars, the smoking prevalence for the lesbian and gay population in California (19.3%) is higher than the general population (14.9%). Among bisexual men (41.1%) and women (28.7%) smoking rates are two to nearly three times that of heterosexuals (Figure 10).

In the Inland Empire, the smoking rate of lesbians, gay men and bisexual men and women (31.5%) is nearly double that of the smoking rate for heterosexuals (17.0%) (CHIS 2007 and 2009).



Transgender data unavailable



Transgender data unavailable

In California, African American lesbians, gay men, and bisexuals appear to have the highest smoking rates overall while heterosexual Latinos have the lowest smoking rates among all groups and LGB Latinos have lowest among all LGB (Figure 11).

Alcohol and Other Drug Use

National Picture

Substance use and abuse affects every segment of our society. The National Institutes of Health (NIH) estimates that slightly more than half of Americans aged 12 or older currently drink alcohol (51.8%) and nearly one quarter (23.1%) of those participate in binge drinking. Additionally, they estimate that 8.9% of the general public use illicit drugs with the rate for males (11.2%) higher than for females (6.8%) (SAMHSA, 2011).

Research indicates that certain LGBT populations exhibit higher rates of lifetime alcohol and drug use over their heterosexual counterparts. Higher rates of substance abuse may be closely linked to other healthcare issues such as sexual risk taking and mental health disorders (Fenway Guide, 2008).

Despite some indication that alcohol and other drug use is declining among LGBT populations, studies of lesbian, gay and bisexual alcohol use demonstrate that, across the nation, rates of drinking and binge drinking are higher than the general population (Table J). Lesbians and bisexual women show the most significant differences in alcohol use patterns, with heavy drinking rates double that of heterosexual women (Hughes & Eliason, 2002; Cochran et al., 2000; Gruskin et al., 2001).

Table J: Estimated Binge Drinking(1) Rates Among Students in Grades 9-12, United States (CDC-MMWR, 2011a)

Heterosexual	Gay and lesbian	Bisexual
20.2%	**26.1%**	**33.1%**

(1) Binge drinking means men drinking 5 or more alcoholic drinks within a short period of time or women drinking 4 or more drinks within a short period of time.

Data on substance use and abuse among the transgender population is limited due to the lack of population based statistics, though in one national survey 8% of respondents reported currently using alcohol or drugs specifically to cope with the mistreatment that they received as a result of being transgender or gender non-conforming. 18% reported using alcohol or drugs in the past for similar reasons (Grant et al., 2011).

As with heterosexuals, LGBT individuals who binge drink are at a higher risk for many health and social problems, including motor vehicle accidents, violence, liver disease, certain cancers, heart disease, sexually transmitted diseases and unintended pregnancies.

Table K: Illicit Drug Use Among Students in Grades 9-12, United States (CDC-MMWR, 2011a)

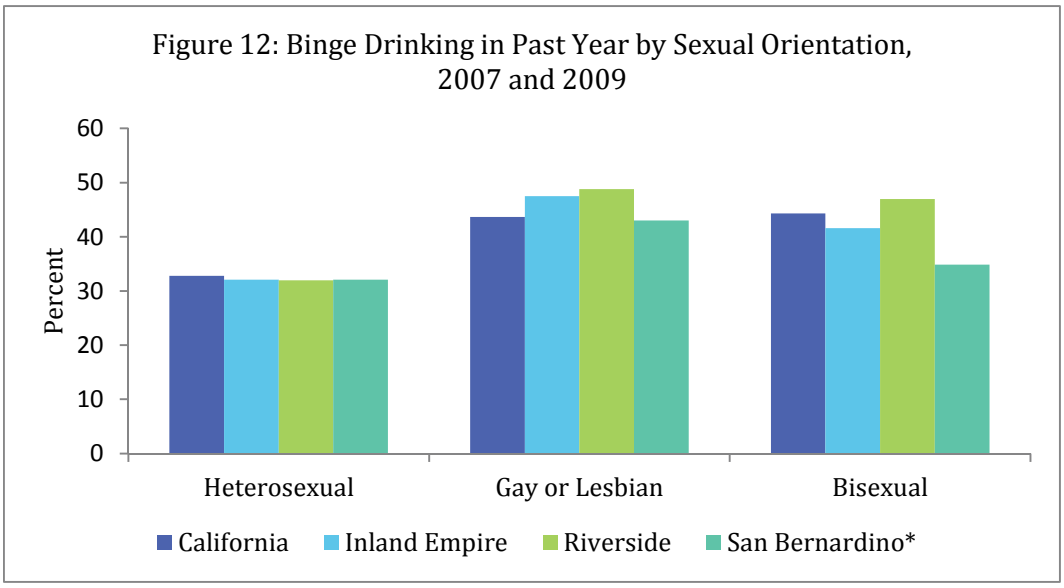
	Heterosexual	Gay or Lesbian	Bisexual
Current Marijuana Use	21.8%	34.5%	36.8%
Ever Used Cocaine	4.1%	22.3%	17.7%
Ever Used Inhalants	7.6%	26.1%	25.9%
Ever Used Ecstasy	4.6%	22.9%	20.4%
Ever used Heroin	1.8%	17.7%	9.6%
Ever Used Methamphetamines	3.4%	21.5%	14.9%
Ever took steroids w/out physician prescription	2.4%	17.1%	10.6%
Ever Injected Any illegal drug	1.5%	14.9%	7.6%

Transgender data unavailable

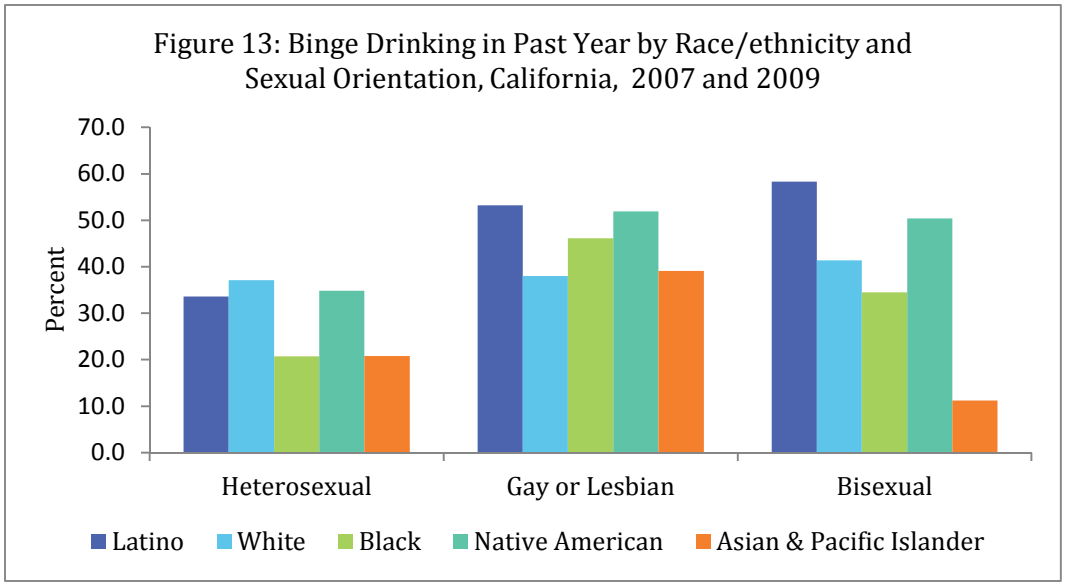
Local Picture

In California, 33% of heterosexual adults report binge drinking at least once in the past year compared to 44% for LGB (CHIS 2007 & 2009). Both Riverside and San Bernardino County data show a similar disparity and conform with research done over the past decade (Figure 12).

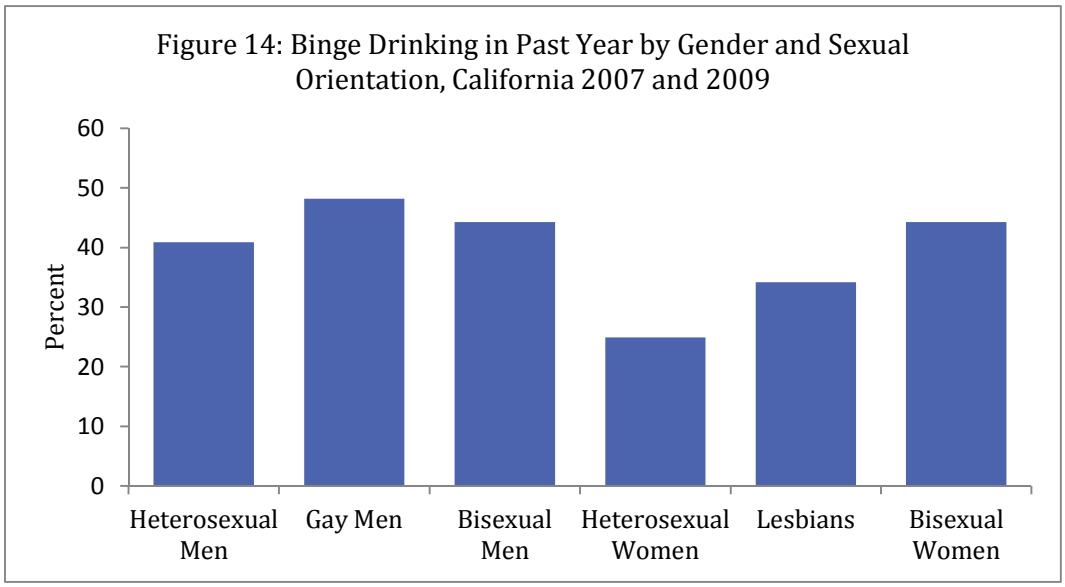
The intersection of sexual minority and racial minority statuses seems to increase risk of binge drinking (Figure 13). In California, non-white LGB binge drink (48.9%) at a rate nearly 20% more than non-white heterosexuals (29.3%) (Figure 13).



Transgender data unavailable



Black and Asian/Pacific Islander bisexual rates and Native American gay and lesbian rates unstable.
Transgender data unavailable



Transgender data unavailable

Eating Disorders, Obesity and Associated Risk Behaviors

National Picture

The prevalence of eating disorders in the United States has continued to increase since the 1950s (Wade et al., 2011). In studies focused on adult LGBT populations, research has demonstrated greater incidence of disordered eating and body image concerns in gay men. Gay men are more likely than heterosexual men to experience poor body image and related eating disorder symptoms (Dean et al., 2000; Kaminski et al., 2005; Boehmer et al., 2007). Conversely, lesbians are twice as likely to be overweight or obese as heterosexual women (Dean et al., 2000; Kaminski et al., 2005; Boehmer et al., 2007). Research has also shown that LGBT adults are more likely to be at higher risk of binge-eating and purging behaviors.

Subgroups of LGBT youth also disproportionately engage in weight control risk behaviors (e.g. abstention from eating or engaging in purging behaviors such as vomiting or laxative use), participate in less physical activity and may make poorer dietary choices as compared to their heterosexual peers (Tables L—N) (CDC, 2011a). The CDC's June 6, 2011 Morbidity and Mortality Weekly Report analyzed Youth Risk Behavior Surveillance System (YRBSS) study results from sites around the country. The prevalence among gay, lesbian or bisexual students was higher compared to heterosexual students for behaviors in seven of the ten risk behavior categories including weight management. The seven risk behavior domains analyzed were behaviors that contribute to violence, behaviors related to attempted suicide, tobacco use, alcohol use, other drug use, high risk sexual behaviors, and weight control. These findings were comparable to results of several smaller studies evaluating risk taking behaviors of LGBT youth (Austin et al, 2009). Austin and colleagues (2009) found that gay and bisexual adolescents were more likely than heterosexual adolescents to report binge eating and purging behavior.

Table L: Weight Control Behaviors Among LGB Students in Grades 9-12 (CDC-MMWR, 2011)

	Heterosexual Youth	Gay or Lesbian Youth	Bisexual Youth
Did not eat for 24 or more hours to lose weight or to keep from gaining weight	10.3%	25.0%	26.6%
Vomited or took laxatives to lose weight or to keep from gaining weight	4.5%	17.5%	15.8%

Transgender data unavailable

Table M: Diet and Physical Activity Among LGBT Students in Grades 9-12 (CDC-MMWR, 2011)

	Heterosexual Youth	Gay or Lesbian Youth	Bisexual Youth
Ate fruits and vegetables five or more times per day	20.2%	29.7%	23.9%
Drank soda or pop at least one time per day	22.6%	30.0%	29.5%
Did not participate in at least 60 minutes of physical activity on any day	19.2%	29.0%	27.5%
Physically active at least 60 minutes per day on 5 or more days	38.1%	24.3%	26.8%
Watched television 3 or more hours per day	39.6%	28.6%	35.7%
Played video/computer games or used a computer for 3 or more hours per day	27.7%	32.9%	34.4%

Transgender data unavailable

LGBT youth reported more frequent fruit and vegetable consumption but higher soda consumption compared to heterosexual youth. They also were more likely to report that they did not meet the recommended daily physical activity requirements of sixty minutes per day. LGBT youth were less likely to report being physically active at least 60 minutes per day on 5 or more days. There was variability of sedentary behavior, with almost 40% of the heterosexual youth reporting that they watched at least 3 hours of television per day, while LGBT youth reported more computer entertainment use (Table M).

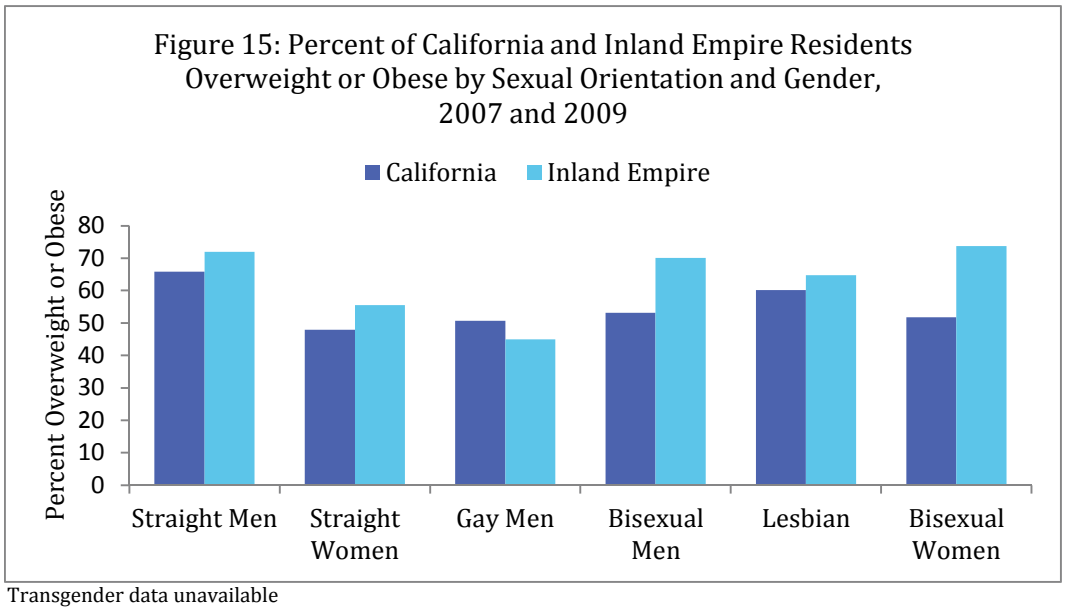
Table N: Overweight and Obesity Among LGB Students in Grades 9-12 (CDC-MMWR, 2011)

	Heterosexual Youth	Gay or Lesbian Youth	Bisexual Youth
Overweight	16.1%	16.4%	19.3%
Obese	10.6%	14.3%	17.1%

Transgender data unavailable

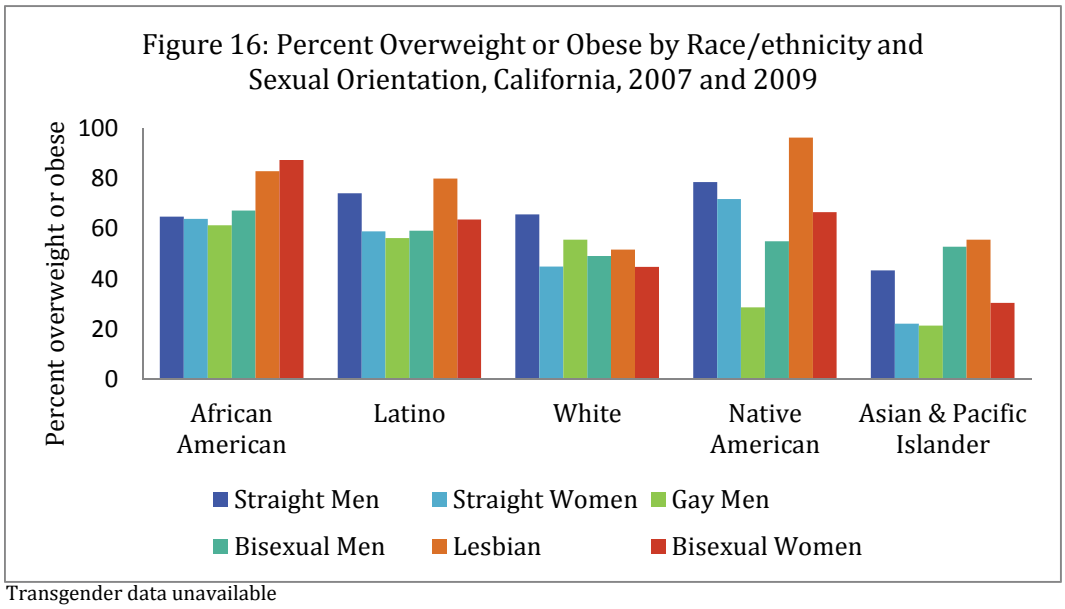
Local Picture

There is no data available to describe disordered eating and weight control behaviors among Inland Empire LGBT adults and youth. We do however have obesity and activity pattern data that is comparable to national data (Figures 15—18).



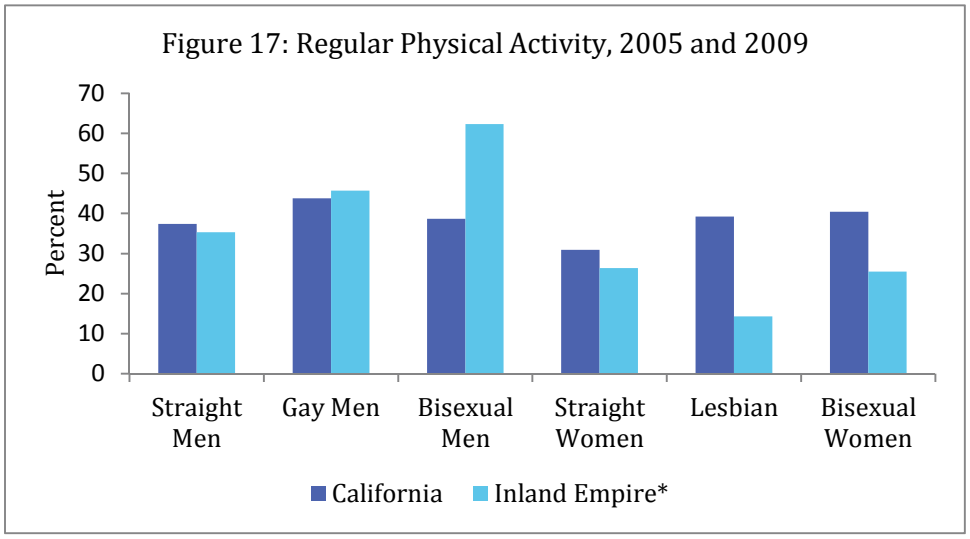
Transgender data unavailable

In the Inland Empire, much of our population surpasses the statewide obesity averages. Among participants of the California Health Interview Survey, heterosexual males and females who were overweight or obese exceeded the state percentage. Bisexual males and females, as well as lesbians, also exceeded the state percentage. Notably, there were more bisexual males and females in the Inland Empire who were overweight or obese compared to the population of bisexual males and females in California. In the Inland Empire, the percentage of gay males reporting that they were overweight or obese was less than in California (Figure 15).



Transgender data unavailable

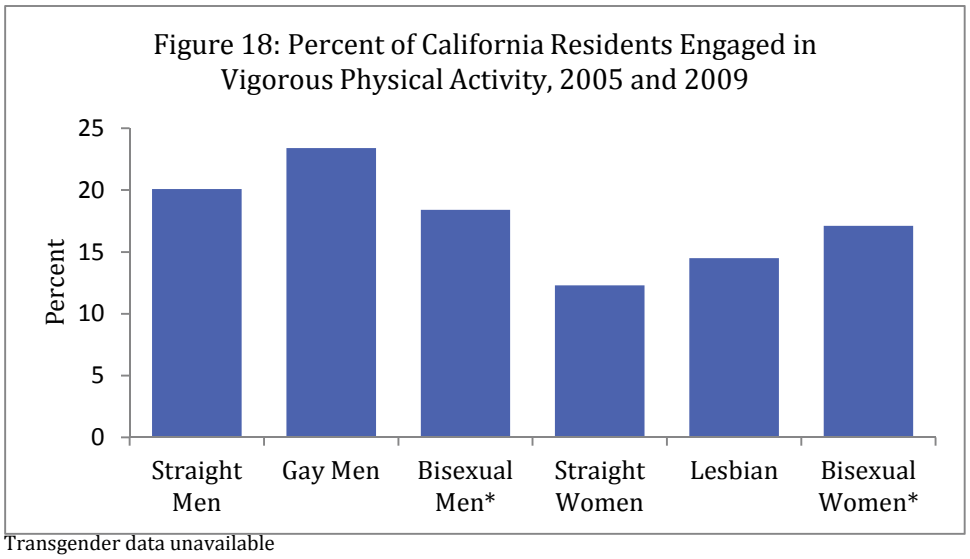
In California, 56.3% of the population is overweight or obese. When comparing obesity percentages by sexual orientation and gender several disparities are evident. Lesbian women, regardless of racial/ethnic group, are more likely to be overweight or obese. Conversely, gay males, regardless of race/ethnicity, are less likely to be overweight or obese.



Transgender data unavailable

In California, sexual minority women and men report engaging in regular physical activity at higher rates than heterosexual men and women (41.3% vs. 34.1%). The differences in self-reported physical activity are particularly pronounced among women. California lesbian and bisexual women report participating in regular physical activity at significantly higher rates than straight women (40.0% vs. 30.9%). Though Inland Empire lesbian, gay and bisexual rates are unstable (see notes on rate instability on page 99) , the trend for gay men is similar to that of California (Figure 17).

Overall state data seen in Figure 18 indicated that greater engagement in vigorous physical activity was seen in gay men, followed by straight men and bisexual men. This trend differed greatly among women California residents. Bisexual women reported the greatest engagement of vigorous physical activity, followed by lesbian women and straight women.



Transgender data unavailable

Sexual Risk Behaviors and Family Planning

National Picture

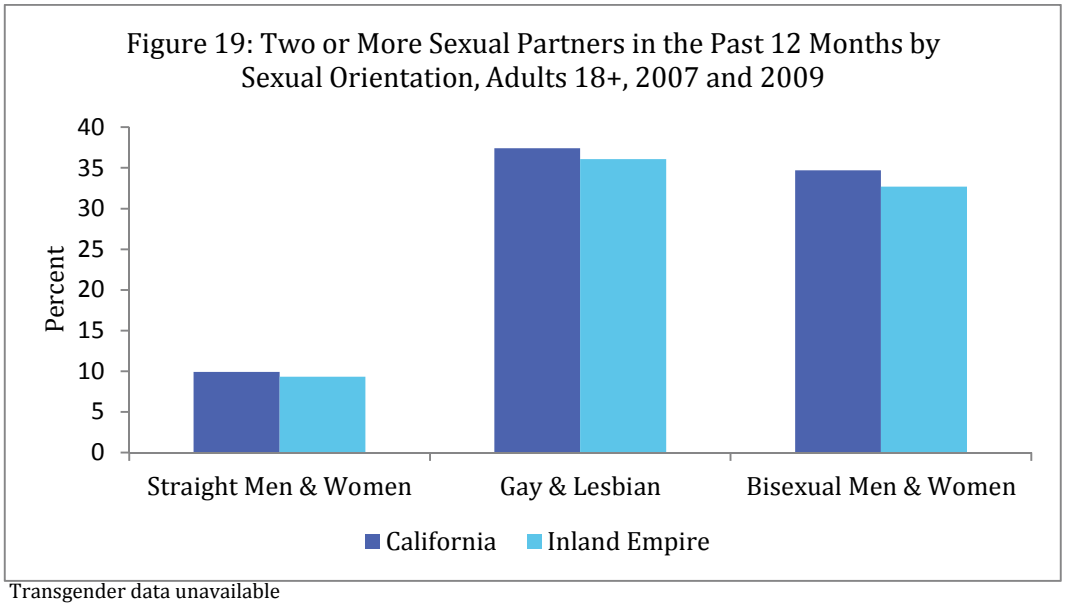
Teens and young adults engage in sexual risk behaviors known to lead to unintended health outcomes such as pregnancy and sexually transmitted infections. In 2011, 47.4% of high school students surveyed reported ever having sexual intercourse. Moreover, 33.7% of high school students reported having sexual intercourse during the last three months; of these, 39.7% did not use a condom during their last sexual encounter and 76.7% did not use a hormonal birth control method (CDC, 2012e).

Multiple studies across the U.S. and Canada have shown that lesbian, gay and bisexual youth are at a two to seven times higher risk of teen pregnancy over their heterosexual peers (Saewyc et al., 2008). Studies have concluded that higher risk behaviors among lesbian, gay and bisexual teens can be linked to "enacted stigma" or elevated rates of harassment, discrimination, and sexual or physical violence (Saewyc et al., 2008).

According to the Youth Risk Behavior Surveillance System, 65.5% of heterosexual youth reported using a condom during their last sexual intercourse, while 35.8% of gay or lesbian youth reported the same. About 53% of bisexual youth reported using a condom during their last sexual intercourse. Contributing factors may include the possibility that lesbian youth may not see need for the use of a condom; often, gay youth only see need for condom use if they are the insertive partner. When females are solicited about their use of pregnancy prevention methods, they are generally not asked about their sexual orientation. This is a missed opportunity for the dissemination of appropriate sexual health information. Inversely, if a man is assumed to be gay, information about pregnancy prevention is not provided increasing the risk of unintended pregnancy. Youth, both heterosexual and LGBT often fail to recognize the importance of condoms or other barrier methods for other sexual activities, which highlights the important role health care providers could play in providing such important information.

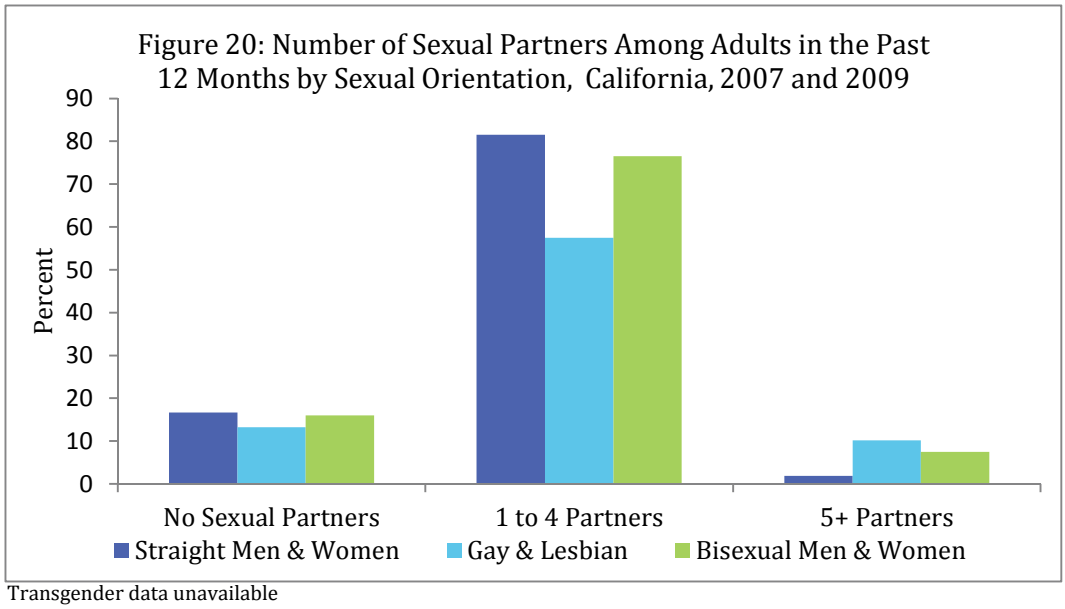
Local Picture

An estimate for sexual activity among local teens is difficult to obtain. Some surveys suggest that nearly one-quarter (21.6%) of California teens and 17% of Inland Empire teens ages 12 to 17 reported not using a condom during their most recent sexual encounter (CHIS, 2003). Information on the sexual practices of adults, and more specifically adult sexual minority groups, is more readily available.



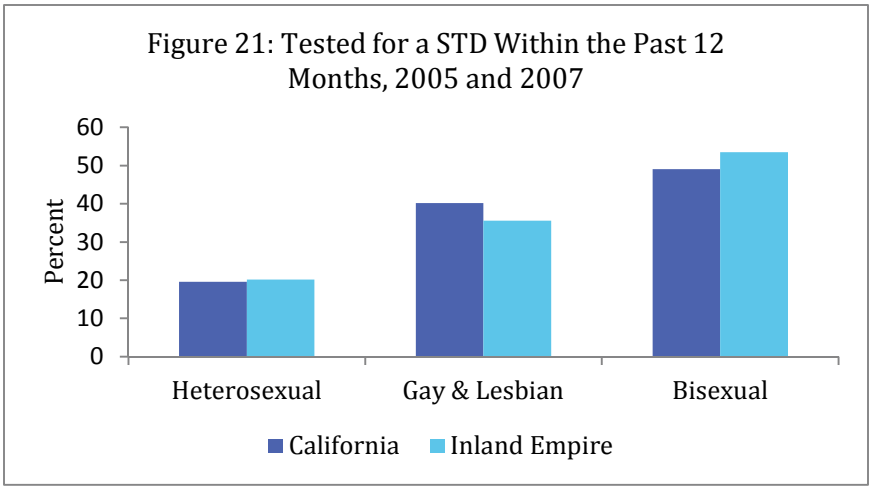
Transgender data unavailable

According to recent data from the California Health Interview Survey, straight men and women in California and the Inland Empire are far less likely to have two or more sexual partners in the past year (Figure 19).



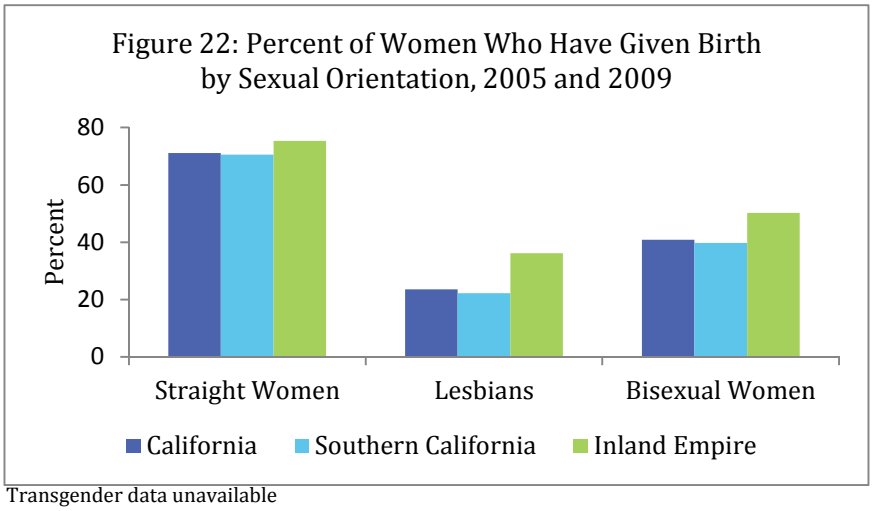
Transgender data unavailable

Taking a closer look at numbers of sexual partners, we find that, as with straight men and women, the majority of LGB reported having between one and four sexual partners in a twelve month period. However, gay men and lesbian women are more likely to have five or more partners when compared to their straight and bisexual counterparts. Gay men and lesbian women are also less likely to have no sexual partners (Figure 20).



Transgender data unavailable

Unlike their straight counterparts, gay, lesbian and bisexual men and women are far more likely to be tested for a sexually transmitted disease (STD) or HIV (Figure 21). Of all of these groups, a greater proportion of bisexual men and women were tested for STDs. This may be a reflection of where services such as STD and HIV screening are more likely to be obtained. Bisexuals are a third more likely to receive their usual health care from a community or government clinic or hospital (page 72, Figure 50). It is well established that community and public clinics are more likely to screen and report cases of gonorrhea and syphilis infections compared to private medical providers (CDC, 2012b). Therefore, the higher rate of STD testing among bisexuals may simply reflect where they are more likely to access health care.



Transgender data unavailable

Straight women are more likely to have given birth compared to lesbian and bisexual women. In the Inland Empire, a greater proportion of lesbian and bisexual women report giving birth compared to their regional and California counterparts; however, this may not be a true difference as the rates are unstable due to the small number of observations.

Large numbers of self-identified lesbians and bisexual women giving birth demonstrates the need for clinicians and other health professionals to address family planning needs among these populations.

Summary

Certain behaviors have been found to increase risks for chronic disease and premature death. These behaviors, referred to as risk factors, include excessive alcohol consumption, use of tobacco, poor dietary practices, physical inactivity, and high-risk sexual behaviors.

Tobacco, Alcohol and Other Drug Use

The excessive consumption of alcohol and the use of tobacco greatly increases the risk of illness and death from cancer and cardiovascular disease. Excessive alcohol use is the third leading lifestyle-related cause of death for the nation and tobacco use in the leading preventable cause of death in the U.S.

- Throughout California, LGB smoke at significantly greater rates than heterosexuals (21.8% vs. 14.3%).
- Across California, LGB report binge drinking in the past year at greater rates than their hetero-sexual peers (41.2% vs. 33.7%).

Eating Disorders, Obesity and Associated Risk Behaviors

Regular physical activity and healthy diets that minimize the consumption of fast convenient foods and sugary beverages and maximizes fruits and vegetables are important for the prevention of chronic illness, healthy weight management and child growth.

- In the Inland Empire and throughout California, straight men have the highest obesity rates followed by lesbians, while gay men and straight women continue to have the lowest rates of overweight or obesity.
- In California, gay men (43.8%) report getting regular physical activity at the greatest rate followed by bisexual women (40.4%), lesbians (39.2%), bisexual men (38.7%), straight men (37.4%) and straight women (30.9%).

Sexual Risk Behaviors and Family Planning

Sexual risk behavior increases the chances of exposure to sexually transmitted infections, as well as, unintended pregnancies. It is well-documented that lesbian, gay and bisexual youth are more likely to experience teen pregnancy or exposure to a sexually transmitted infection. The health education of LGB youth and adults may lack the appropriate sensitivity and messages that are needed in order to prevent these disparate health outcomes.

- An estimated 17% of Inland Empire teens (12-17 years old) of any sexual orientation reported not using a condom during their most recent sexual encounter.
- Inland Empire adult lesbians, gay men and bisexuals are more likely to have reported two or more sexual partners over a 12 month period than heterosexuals.
- Inland Empire lesbians, gay men and bisexuals are more than twice as likely as heterosexuals to receive an STD test within a 12 month period (43.7% vs. 20.2%).
- Over a third (34.9%) of Inland Empire lesbians and bisexual women have given birth.

Health Conditions

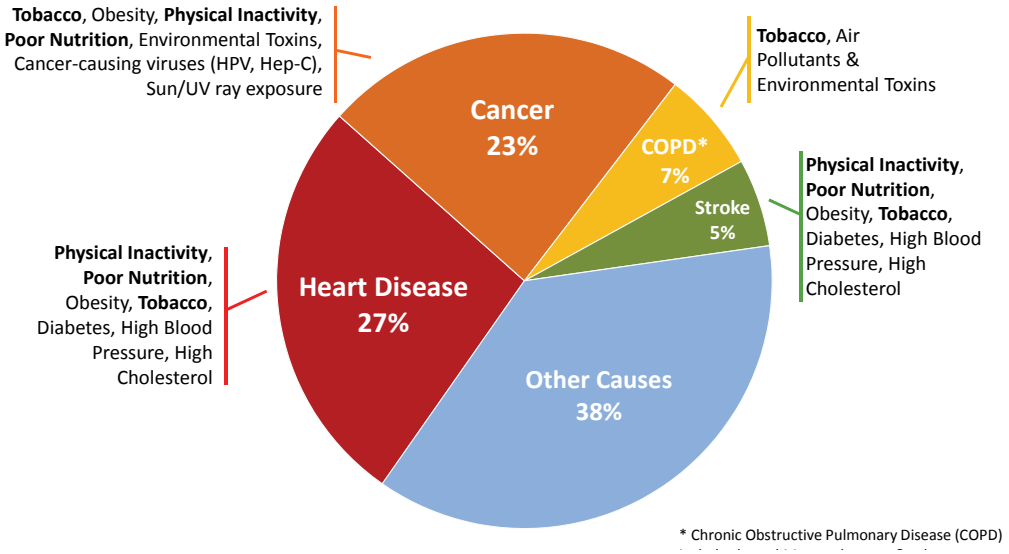
Finding meaningful and timely statistics on the health status of local populations can be challenging. Gauging the health status of minority populations presents an even greater challenge and the LGBT population is no exception. Since most data sources do not ask individuals to identify themselves by sexual or gender identity, understanding the prevalence of disease within the LGBT population is often difficult for many health conditions.

Within the LGBT population a variety of risk factors that contribute to elevated burden of chronic and communicable disease result from social status, marginalization, and discrimination. Stress, delay of care, incompetent care, lack of insurance, poverty, and increased reliance on harmful coping behaviors (e.g., smoking, drinking, binge eating, unprotected sex) all raise the risk of experiencing negative health outcomes.

Chronic Disease

The burden of chronic disease is an essential consideration of the overall health of the LGBT population. Just as heart disease, stroke, cancer, and COPD cause over 60% of early deaths in Riverside County (Figure 23), these conditions rob years of potential life from our LGBT community as well. Though we are unable to determine the exact LGBT mortality and morbidity burden using death and hospitalization data, we can examine the prevalence of a variety of chronic disease indicators and risk factors using local survey data. The more risk factors a person has, the higher the chances of developing or exacerbating a chronic disease.

Figure 23: Leading Causes of Death and Contributing Risk Factors, General Population, Riverside County, 2012



Heart Disease

National Picture

Heart disease includes diseases and conditions of the heart and arteries such as coronary heart disease, heart failure, heart attack, arrhythmias, angina, and many others. Heart disease is a leading cause of death and is a critical public health concern among all U.S. populations. The more risk factors a person has, the greater the chance that they will develop heart disease. Some factors that raise an individual's risk include alcohol and tobacco use, physical inactivity, and obesity. All have been found to be more prevalent among segments of the LGBT population (SAMHSA, 2012).

Data on the prevalence of heart disease in LGBT populations is limited. One study found that lesbians were significantly more likely than heterosexual women to receive a diagnosis of heart disease; meanwhile, bisexual women, though less than that of lesbians, also had elevated diagnoses relative to heterosexual women (IOM, 2011). Most recently, Farmer and colleagues (2013), found that sexual minority women to be at increased risk for cardiovascular disease even after controlling for negative coping behaviors (i.e. alcohol, tobacco and other substance use). A finding they found consistent with Meyer's minority stress theory (Meyer, 2003).

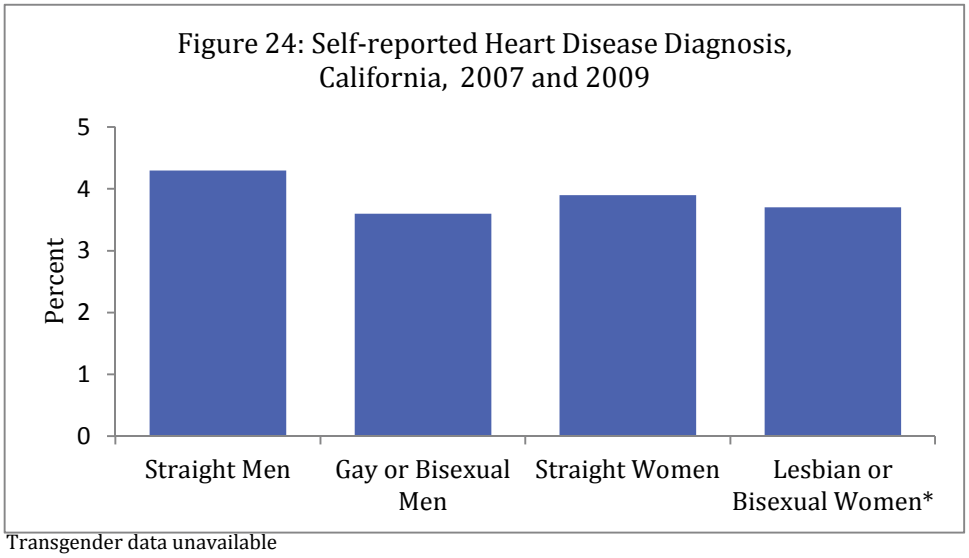
The small amount of research on heart disease in the LGBT community has been focused on the increased risk among those infected with HIV. Those studies do suggest that antiretroviral treatment may be associated with an increased risk of cardiovascular events, such as heart attack; though not enough research has been conducted to firmly establish these risks (IOM, 2011).

For transgender individuals, studies examining the effects of hormone therapy on heart or cardiovascular disease have had mixed results though some suggest an increase in serum triglycerides (blood fat levels) among those using hormone therapy (IOM, 2011).

Image Courtesy of Stockvault.net

Local Picture

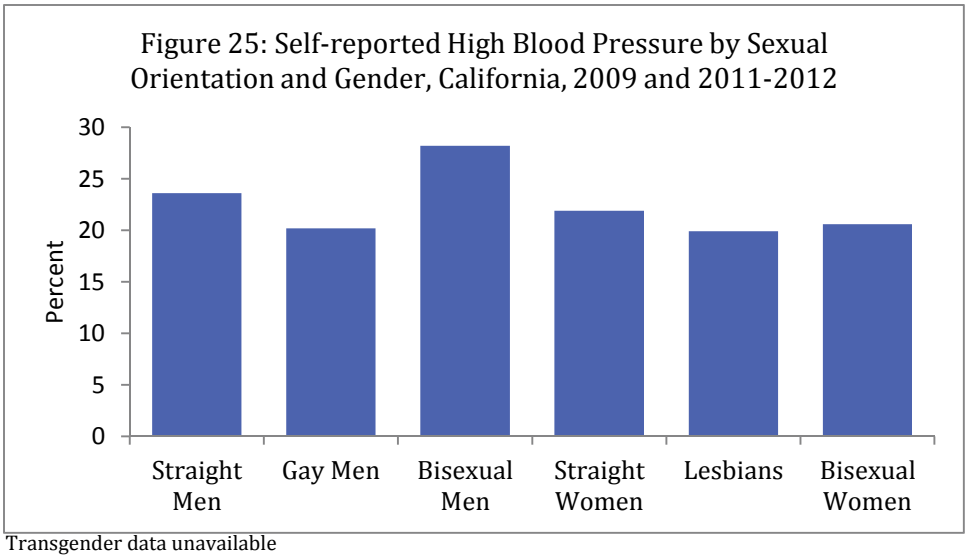
In California, the lesbian, gay, and bisexual community is less likely to report receiving a diagnosis for heart disease than the heterosexual community (Figure 24). While the percentages are not dramatically different between the groups, straight women and men both reported higher heart disease prevalence than their gay, lesbian and bisexual peers.



Transgender data unavailable

Bisexual men have the highest self-reported prevalence of high blood pressure and gay men report the lowest. Improved diet and exercise among many gay men may be a protective factor against high blood pressure (see pages 35-37).

Despite higher rates of some risk behaviors, lesbians, gay men and bisexuals in California self-report lower rates of heart disease and no significant difference in high-blood pressure or stroke. The Inland Empire trends are similar. However, additional research is required given the prevalence of risk factors, the lack of studies that have been conducted, and the limitations of self-reported diagnoses.



Transgender data unavailable

Cancers

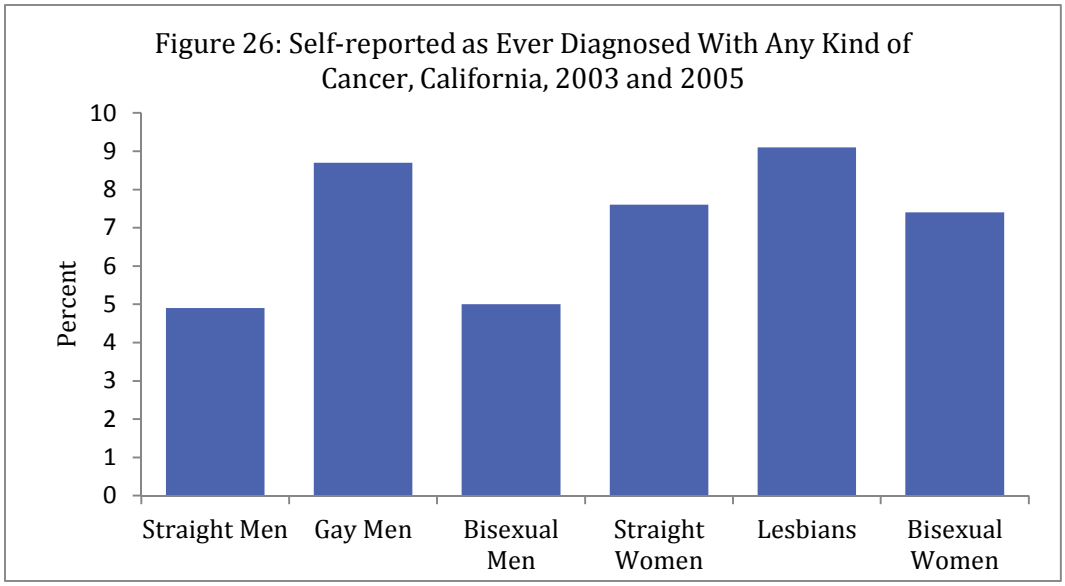
National Picture

Data on sexual orientation and gender identity is not currently collected among the National Program of Cancer Registries making it impossible for researchers to use the most comprehensive cancer databases in the nation to estimate the incidence and prevalence of cancer among sexual and gender minorities (IOM, 2011). However, there are several areas of concern for the LGBT community. Researchers are trying to understand the relative risk of breast cancer among different groups of women. Higher prevalence of known risk factors such as nulliparity, alcohol consumption, smoking, and obesity may place lesbians at higher risk (IOM, 2011).

Among gay and bisexual men, an increased risk for anal cancer has been established. Anal cancer, like cervical cancer, is associated with the human papillomavirus (HPV), an infection which can be transmitted through anal intercourse (IOM, 2011).

Very little is known about the cancer risks among transgender men and women. Some researchers have expressed concern over the long term use of feminizing or masculinizing hormones, though the main risk appears to be cancer screening with trans-women not receiving prostate examinations and trans-men not receiving breast exams delaying early detection of these cancers (IOM, 2011).

Local Picture



Transgender data unavailable

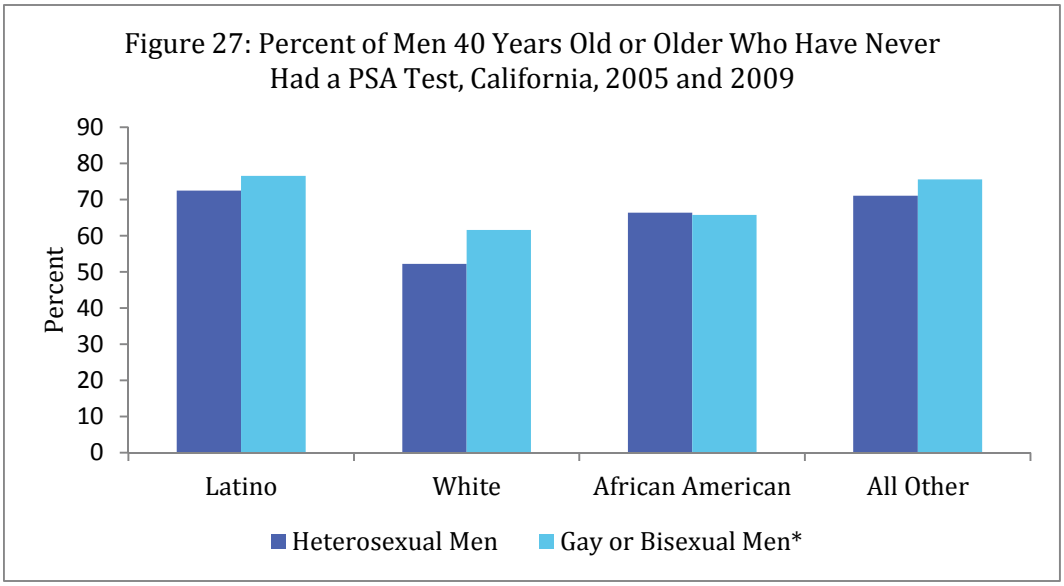
In California, gay men and lesbians report the highest lifetime diagnoses of any type of cancer (Figure 26). Available data shows similar trends in Riverside and San Bernardino Counties though small sample sizes makes analysis difficult.

Cancer Screening

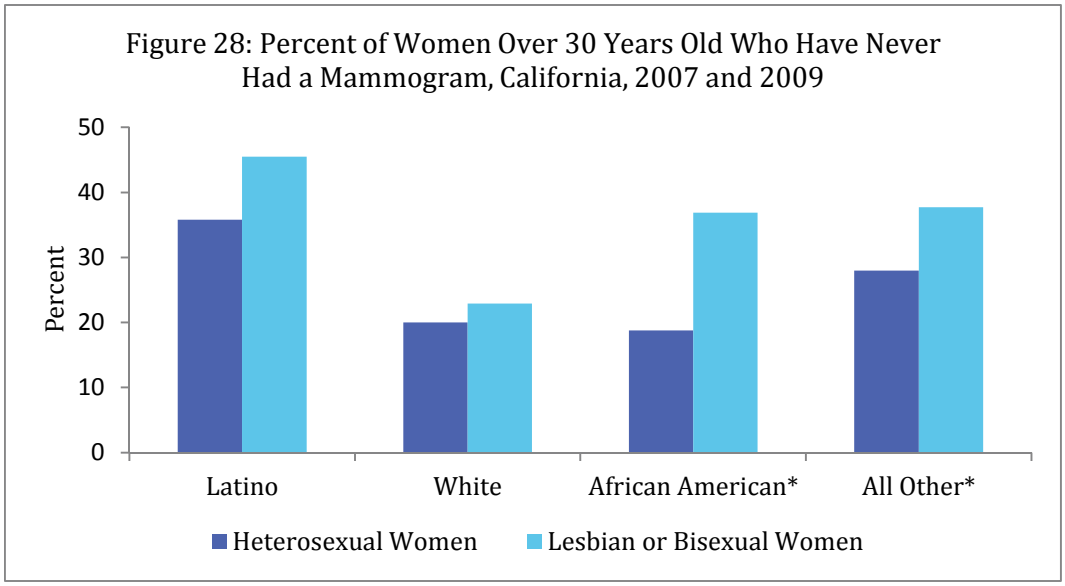
LGBT populations may be less likely than heterosexual/gender-conforming men and women to use preventive cancer-related screening services such as mammography, Papanicolaou (Pap) tests and prostate-specific antigen (PSA) testing. Further, transgender men and women often do not receive biologically appropriate screenings (such as trans-men not receiving Pap tests when indicated) (IOM, 2011). Lower rates of screening might result in later detection of cancers, and increase the severity of illness and frequency of death. This could be because of several factors including experiences with discrimination in health care settings, lower rates of insurance in the absence of the safety net of spousal health benefits, and fewer cues, such as contraceptive needs, to trigger seeking of routine gynecologic care (Cochran et al, 2001; Fredriksen-Goldsen et al, 2013).

Local Picture

Within California, gay and bisexual men receive PSA tests at nearly the same rate as heterosexual men. Race/ethnicity appears to be a larger factor than sexual orientation for rates of testing. The exception is white gay and bisexual men who are tested at rates higher than other race/ethnicities, but are tested less than their white heterosexual counterparts (Figure 27).

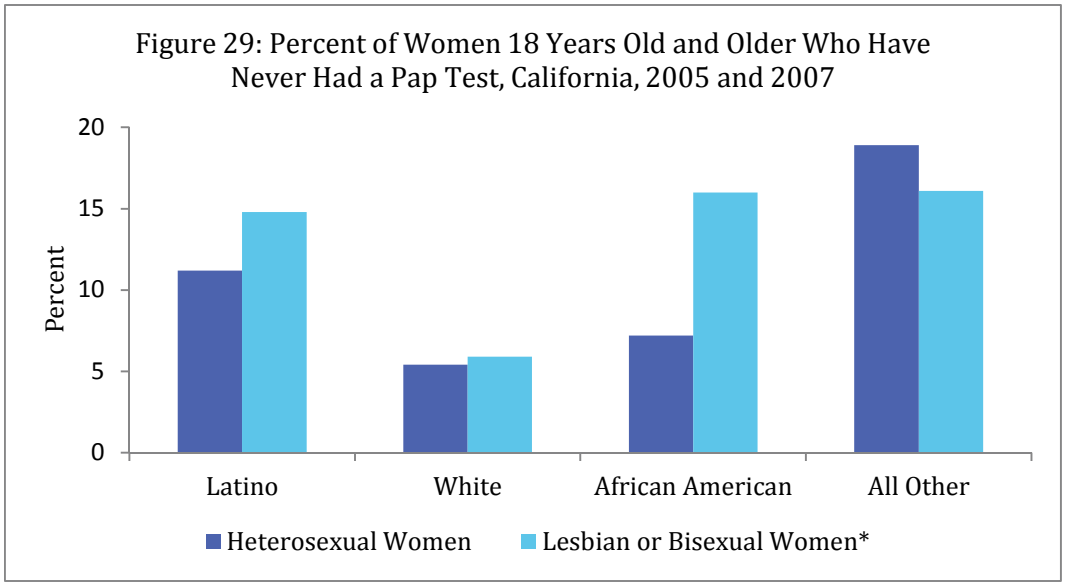


Transgender data unavailable



Transgender data unavailable

In California, Latina, white, and African American heterosexual women receive mammograms and Pap tests at greater rates than their lesbian and bisexual peers. Race and ethnicity though appears to be a more significant factor than sexual orientation (Figures 28 and 29). Riverside and San Bernardino County data was unavailable due to small sample sizes.



Transgender data unavailable

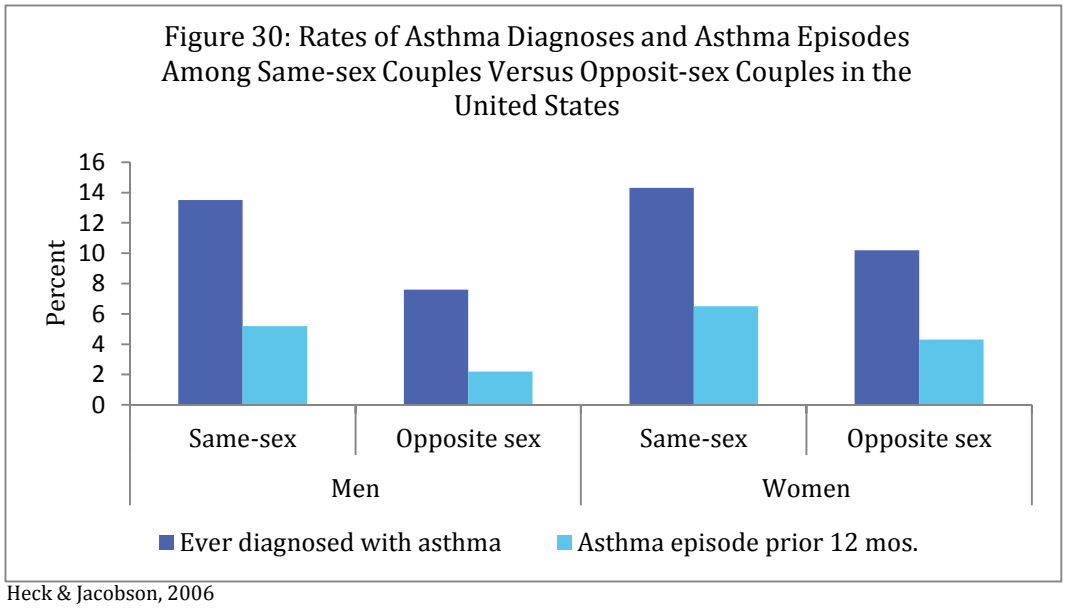
Asthma and COPD

Cigarette smoking has been shown to be a major risk for both asthma and chronic obstructive pulmonary disease (COPD). LGBT communities are more likely than the general population to engage in, or be exposed to, known asthma and COPD triggers such as smoking, urban residence, high stress, and, obesity.

Very little research has been conducted on the prevalence of COPD specifically among the LGBT population, though percentages of self-reported diagnosis of lung disease other than asthma were similar among all sexual orientations in one population-based survey (CHIS 2005). More research has been conducted on asthma among minority populations.

National Picture

Using population level data from the National Health Interview Surveys, Heck and Jacobson (2006) found that in the United States, men and women in same-sex relationships where significantly more likely to have been ever diagnosed with asthma than those in opposite sex relationships (Figure 30). They are also more likely to be current or former smokers, report high levels of stress, be overweight if they are women in same-sex relationships. All these are known risk factors for asthma.

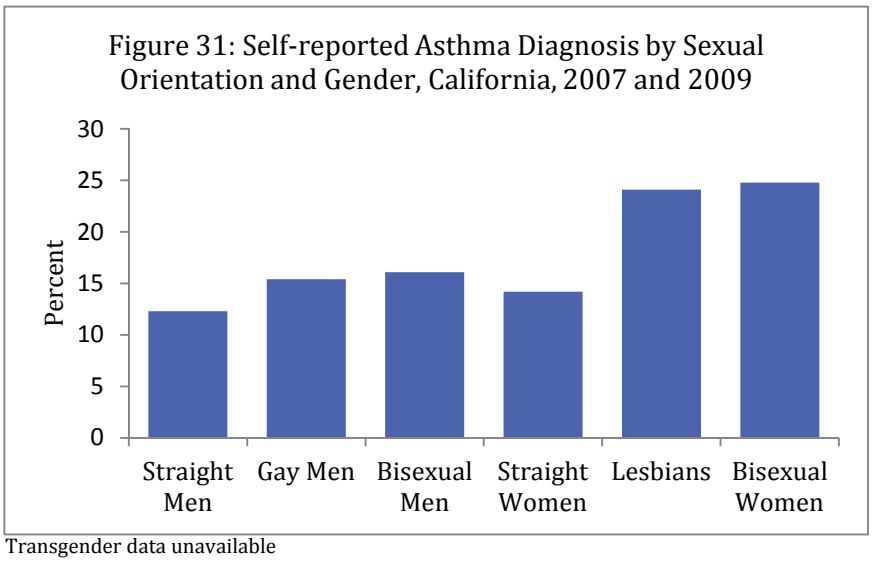


Heck & Jacobson, 2006

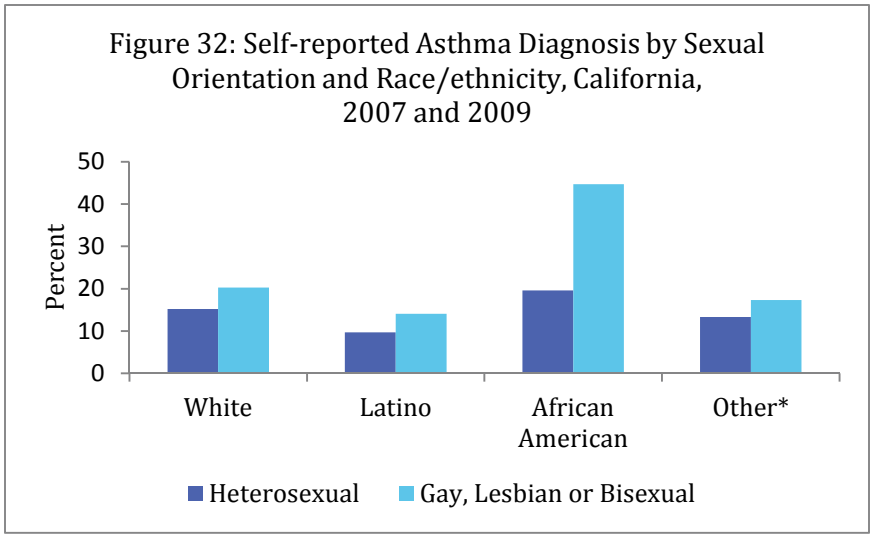
Local Picture

The overall self-reported asthma rates for the general population of California (13.5%), Riverside County (16.1%), and San Bernardino County (13.0%) are lower than rates for gay, lesbian and bisexual men and women. Statewide, lesbians (24.1%) and bisexual women (24.8%) report asthma diagnoses at the highest rates compared to all other sexual orientations (Figure 31). Data for Riverside and San Bernardino Counties are similar though small sample sizes at the county level introduce some uncertainty (CHIS 2007/2009).

In California (Figure 32) both straight (19.6%) and LGB (44.7%) African Americans report the highest lifetime asthma diagnosis rates of all populations (CHIS 2007/2009).

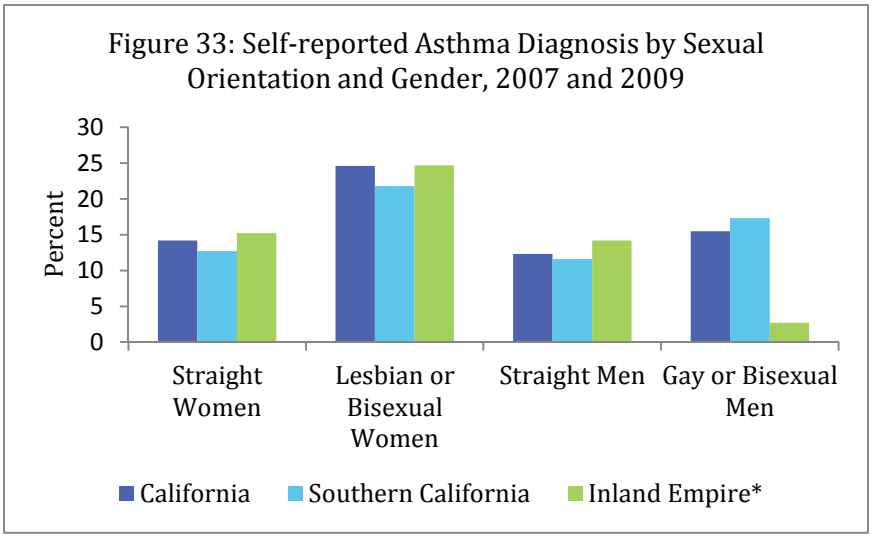


Transgender data unavailable



Transgender data unavailable

In the Inland Empire, lesbian or bisexual women reported to have approximately 25% of asthma diagnoses while 15% diagnoses were present in their heterosexual counterparts. In contrast, gay or bisexual men reported less than 5% of asthma diagnoses, which was dissimilar with the reported 15% from their heterosexual counterparts (Figure 33).



Rates for Inland Empire lesbians, gay men and bisexuals are unstable.
Transgender data unavailable.

Stroke

In the United States, nearly 130,000 people die from cerebral vascular disease (stroke) annually. Major risk factors include high blood pressure, heart disease, diabetes, and cigarette smoking. Unfortunately, insufficient data is available on the incidence of stroke in LGBT populations. One 2005 population level survey of Californians did find similar rates of self-reported stroke diagnoses among the lesbians, gay men, and bisexuals and the general population (CHIS, 2005).

Diabetes

National Picture

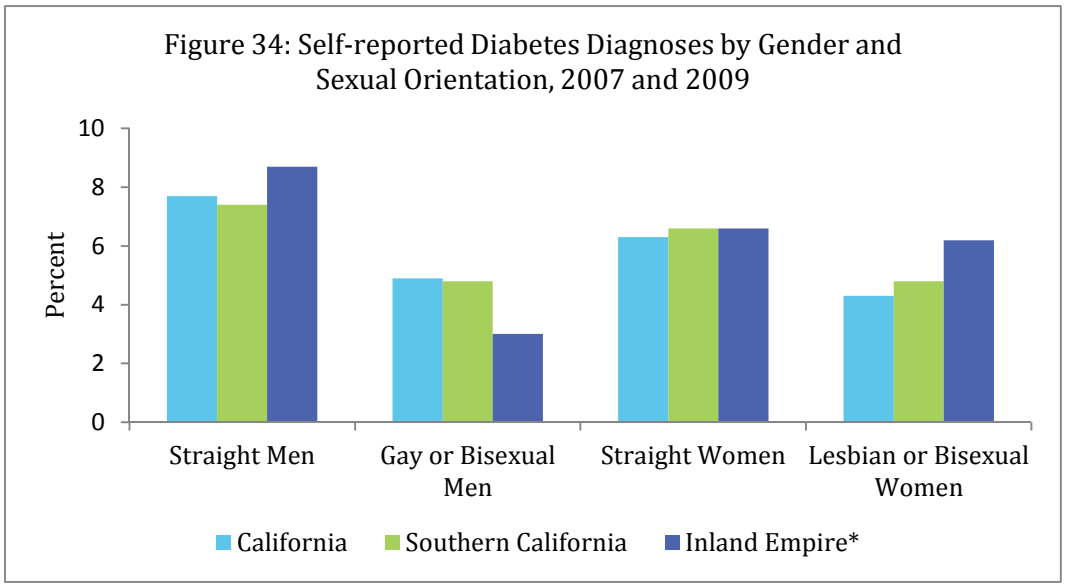
Diabetes affects 25.8 million people in the United States, 90-95% of whom have type 2. As the seventh leading cause of death in the nation and a leading cause of heart disease and stroke, diabetes is a serious public health concern (CDC, 2011b). Current national prevalence estimates of diabetes within LGBT communities are unavailable though the pervasiveness of diabetes risk factors among these populations raises concern.

Diabetes risk factors of particular concern to LGBT populations include:

- High smoking rates
- Higher polycystic ovarian syndrome (PCOS) prevalence among some lesbians (Agrawal, et al., 2004)
- Rates of overweight and obesity
- Rates of delay of medical care
- Eating disorders among gay men
- Illicit substance use and binge drinking
- Hostility and/or cultural incompetence among health providers

Local Picture

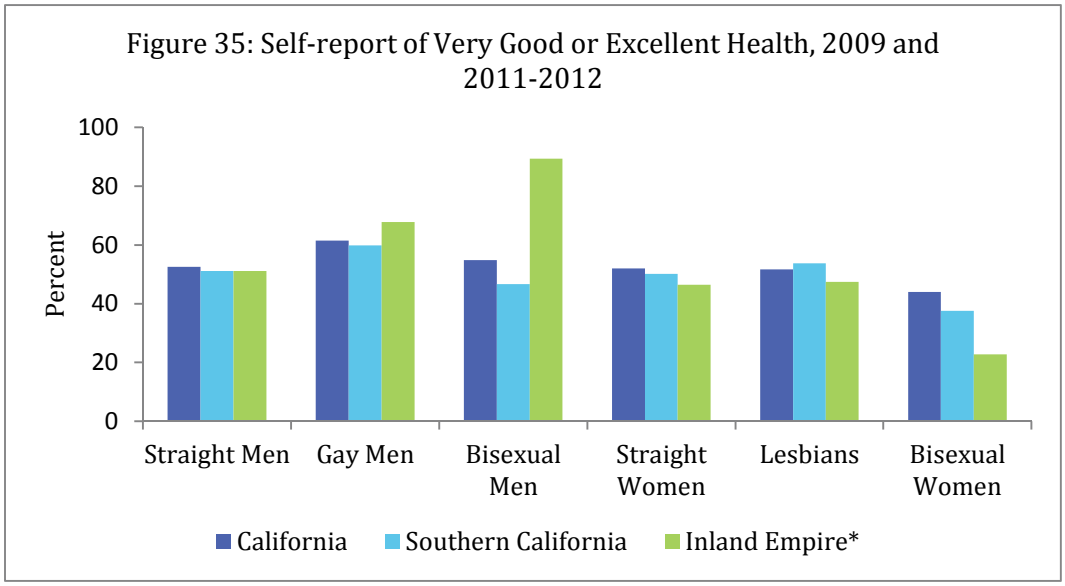
In the Inland Empire and statewide, bisexual women and gay men seem to have the lowest self-reported diabetes rates while straight and bisexual men have the highest (Figure 34). Though this data was statistically unstable, it does indicate more research is necessary.



Transgender data unavailable

Health Status

In the Inland Empire, 15.6% of the general population reported fair or poor health with 84.4% reporting good, very good, or excellent general health.



Inland Empire rates for bisexual men and women and lesbians are unstable.
Transgender data unavailable

As demonstrated in Figure 35, most residents in the Inland Empire do not differ on self-report of health as compared to Southern California or California as a whole. Approximately 50% of straight men in all three geographical groupings reported having very good or excellent health. Almost 70% of gay men in the Inland Empire reported better health status while only 59.9% of gay men in Southern California and 61.5% in California reported very good or excellent health. While the percentage for the Inland Empire may be subject to instability, 89.4% of bisexual men reported having superior health. This was significantly more compared to Southern California (46.7%) and California (54.9%). In general, gay or bisexual men living in the Inland Empire reported better overall health status compared to Southern California or California in general.

For straight, lesbian or bisexual women, the opposite was reported. Compared to Southern California and California, fewer straight, lesbian or bisexual women in the Inland Empire reported having very good or excellent health. This was especially pronounced for bisexual women, with only 22.8% reporting good health status as compared to their counterparts in Southern California (37.6%) and California (44%). Though there is instability in the reported percentage of Inland Empire bisexual women having good health status, almost 50% fewer reported good health status compared to California. The reported health status percentages for women across all sexual orientation categories were the opposite of what was seen for men and lower than what the men reported.

Disability

In *Health Disparities and Inequalities Report-United States, 2011,* the CDC identifies two main gaps in current health disparities research: disparities related to disability and those related to sexual orientation (CDC, 2011c). Since LGB adults are a health-disparate population and those living with disabilities often do not have access to adequate health care services, LGB adults with disabilities may face multiple and serious health risks (Fredriksen-Goldsen et al, 2012).

National Picture

A study conducted by Fredriksen-Goldsen et al. (2012) found that Washington state lesbian, gay, and bisexual adults showed higher prevalence of disability compared to their heterosexual counterparts. In this study, 25% of heterosexual women, 36% of lesbians, and 36% of bisexual women were disabled. Among men, 22% of heterosexuals, 26% of gay men, and 40% of bisexual men were disabled. Further, 30% of respondents to the National Transgender Discrimination Survey (Grant et al 2011) also reported physical or mental health disability.

Local Picture

Table O: Disabled (self-report) Due to Physical, Mental or Emotional Condition 2009 and 2011—2012

	Heterosexual Men	Gay Men	Bisexual Men	Heterosexual Women	Lesbians	Bisexual Women
California	24.1%	23.5%	38.8%	26.0%	33.9%	43.8%
Southern California	24.8%	24.9%	42.3%	25.8%	27.7%	44.0%
Inland Empire	27.7%	30.1%*	45.0%*	30.5%	22.4%*	42.1%*

Transgender data unavailable

Local data (Table O) accumulated from the years 2009, 2011, and 2012, indicate that 30.1% of gay men and 45% of bisexual men in the Inland Empire, report a higher prevalence of disability compared to their heterosexual counterparts. Also, 30.5% of heterosexual women reported a disability in contrast to 22.4% of lesbian women and 42.1% of bisexual women. Inland Empire gay and bisexual men reported higher rates than their peers in Southern California or California (CHIS 2009 and 2011-2012). Although the Inland Empire rates are unstable, observations should still be noted and efforts made to obtain larger sample sizes that more accurately reflect this population.

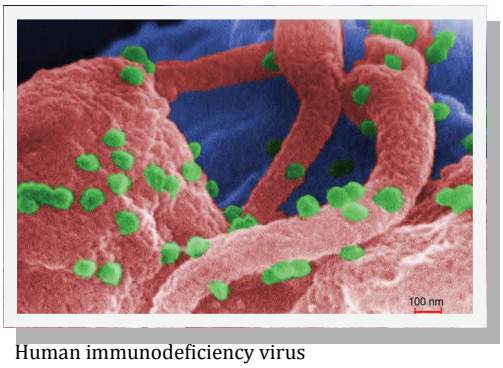
Communicable Disease

Communicable diseases are infectious diseases that can pass from person to person by direct contact (touching, kissing, etc.) or by contact with bodily fluids/discharges, air, or items used by an infected person. In addition to these infectious diseases, the public health department also monitors diseases that can spread to humans through contact with animals, insects, and the environment (air, water, and soil). Control of communicable disease is a core function of public health and there are various laws, policies, and programs in place to facilitate this effort.

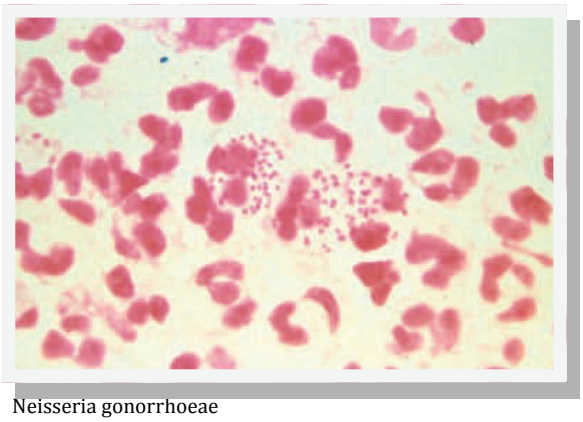
Surveillance and Disease Reporting

Cases of communicable diseases are reported to the health department through a network of laboratories and clinicians who are required to report these cases by law. The communicable disease surveillance system collects some basic information but does not currently require that patients identify their sexual orientation. Except for a few specific diseases like syphilis and HIV where public health officials routinely conduct additional detailed interviews with patients, sexual orientation is not generally ascertained and so there is little available data on broad communicable disease trends among the LGBT population.

Treponema pallidum (Syphilis)



Human immunodeficiency virus



Neisseria gonorrhoeae

Photos this page from: Centers for Disease Control and Prevention.

Sexually Transmitted Infections

HIV and other STD investigations report on a patients' sexual behavior rather than their sexual identity. Therefore, much of the following data is presented for "men who have sex with men" (MSM) who may or may not identify as gay or bisexual.

Far less research has been completed on "women who have sex with women" (WSW) though as noted in the Institute of Medicines report (2011) large numbers of WSW may also have unprotected anal, oral and vaginal sex with both men and women and many have reported sharing of sex aids.

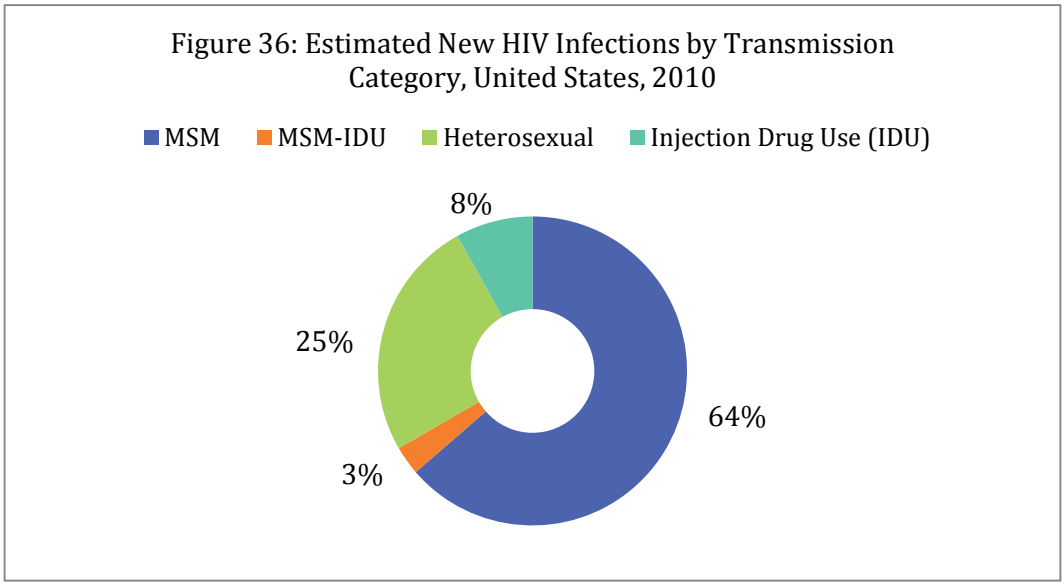
HIV-AIDS

The first reported case of AIDS in Riverside County was in 1983. In the 30 years since, over 6,000 cases of AIDS have been reported to the Department of Public Health and 2,838 county residents have lost their lives to AIDS. There are currently 4,747 persons known to be living with HIV/AIDS in Riverside County. The reporting of HIV infection became a legal requirement in California in 2002. Since then, 1,553 known infections have been reported. It is believed, however, that more than 20% of infected individuals are unaware that they are infected. Due to advances in treatment, HIV infection is no longer the death sentence it once was. Early diagnosis and referral to medical care can increase the lifespan and quality of life of those infected with HIV and reduce HIV transmission to others. The Centers for Disease Control and Prevention (CDC) recommends routine HIV testing for all adults, adolescents, and pregnant women so that individuals testing positive can be diagnosed and treated before the infection causes illness.

National Picture

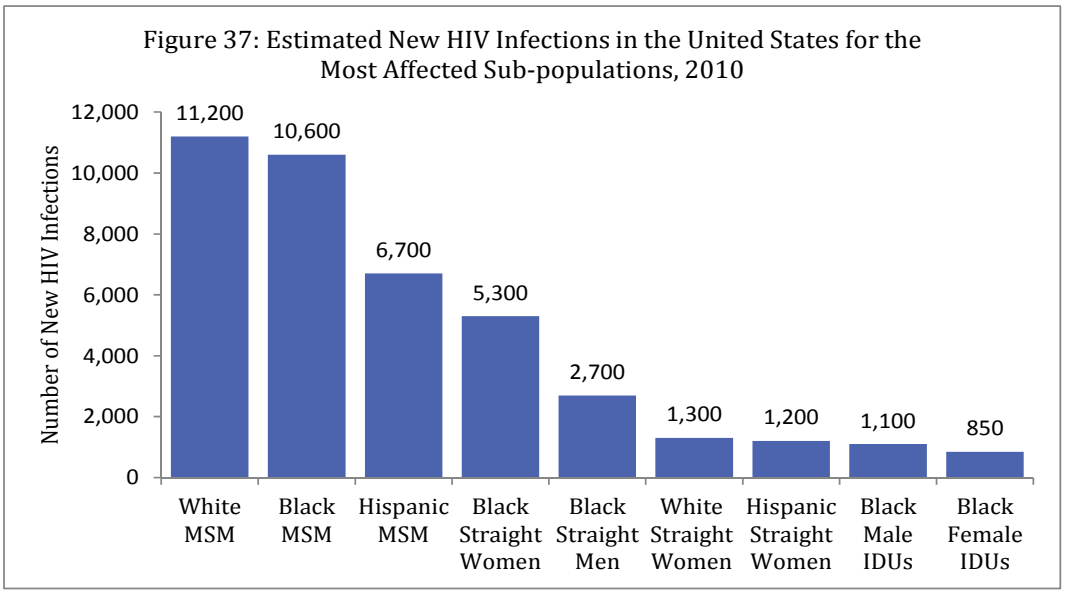
Gay, bisexual, and other men who have sex with men (MSM) are more severely affected by HIV than any other group in the United States and account for 67% (including people who are both MSM and injection drug users 3%) of all new infections (Figure 36).

According to the CDC, individual risk behavior alone cannot account for the disproportionate burden of HIV among MSM. Other factors could include "higher prevalence of HIV among MSM, which leads to a greater risk of HIV exposure with each sexual encounter; the high proportion of young MSM (especially young MSM of color) who are unaware of their infection, which increases the risk of unknowingly transmitting the virus to others; stigma and homophobia, which deter some from seeking HIV prevention services; barriers, such as lack of insurance and concerns about confidentiality, that result in less access to testing, care, and antiretroviral treatment; and high rates of some STDs, which can facilitate HIV transmission. Additionally, many young MSM may underestimate their personal risk for HIV" (CDC, 2012d).



CDC 2012d

In the United States, men who have sex with men (MSM) under 25 years old carry a disproportionate burden of HIV infection. This is particularly true for MSM who also belong to racial/ethnic minority groups. African Americans who are approximately 13% of the U.S. population comprise about half of all new HIV infections (Figure 37). Young African American men less than 25 years old who have sex with men account for more new infections in the United States than any other group (CDC, 2012d).

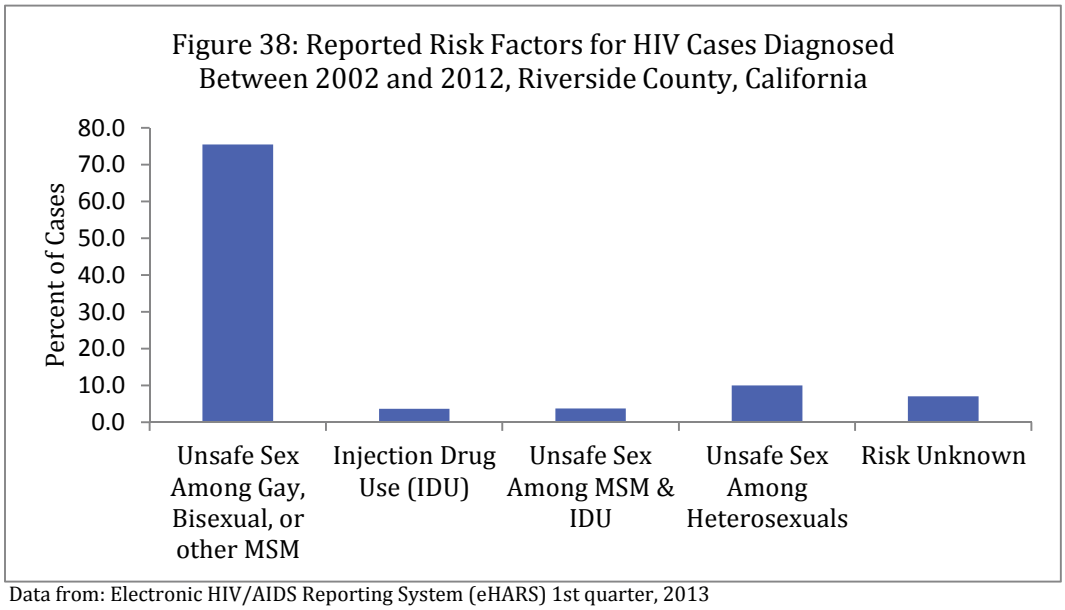


CDC 2012d

Local Picture

Riverside County has the fifth highest number of HIV cases and sixth highest number of AIDS cases of any county in California. In Riverside County from 2002-2012, over three-quarters of newly diagnosed HIV cases have been among gay, bisexual or other men who have unprotected sex with men (MSM) (Figure 38). As of December 31, 2012, there were 3,374 people reported living with AIDS and 1,712 people living with HIV in the County. Of those, 85% (4,344) are gay, bisexual or other MSM. In contrast 10% of all HIV cases diagnosed since 2002 were through unsafe heterosexual sex.

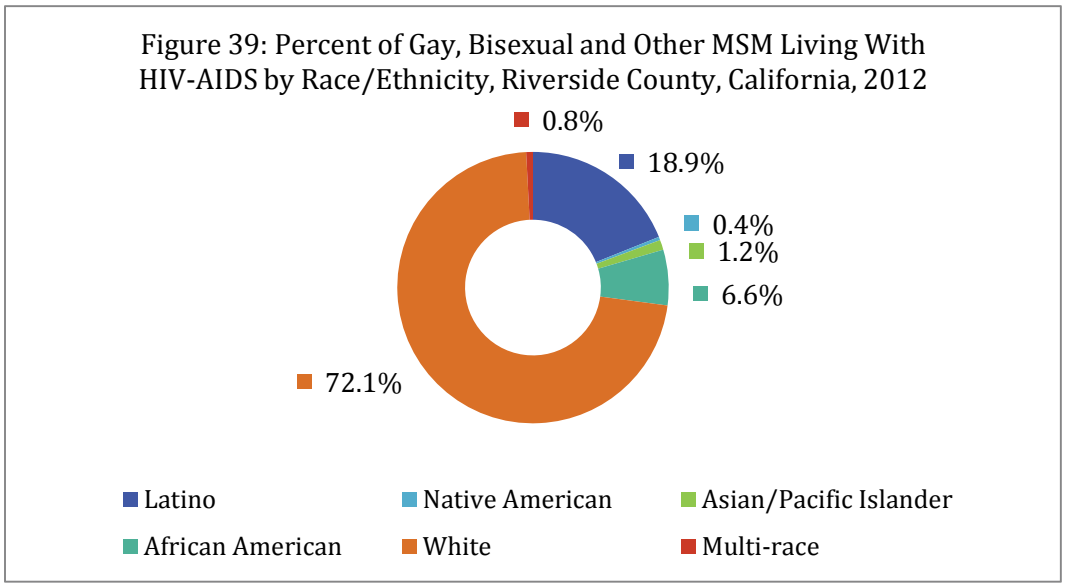
Within the County, the Coachella Valley is disproportionately impacted by the epidemic with almost three times the number of persons living with HIV or AIDS (PLWH/A) than any other County region.



Data from: Electronic HIV/AIDS Reporting System (eHARS) 1st quarter, 2013

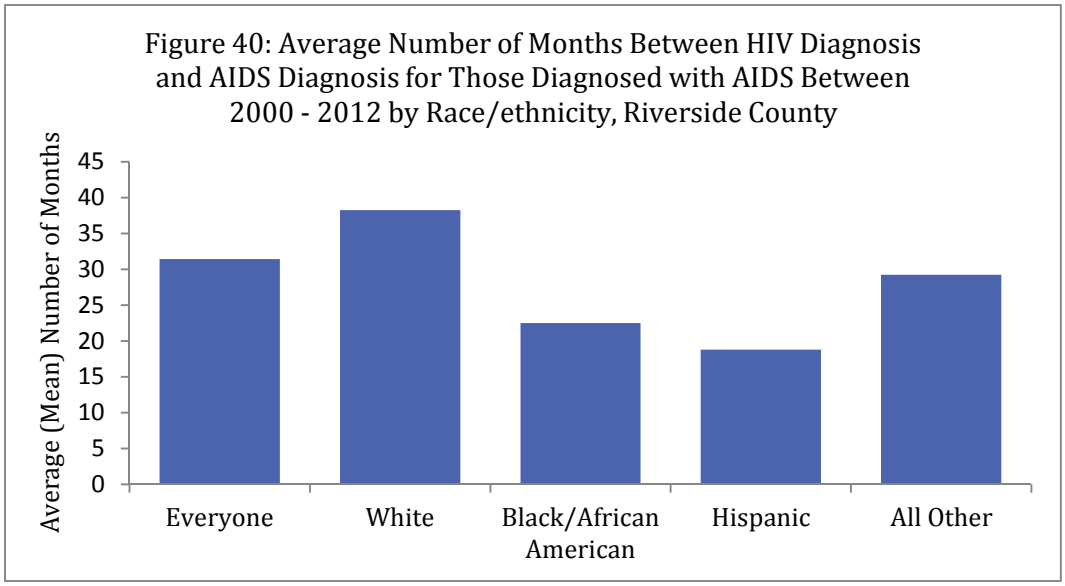
Riverside County men of all sexual orientations make up more than 90% of both HIV and AIDS cases.

As of December 31, 2012, there were an estimated 19 transgender persons living with HIV/AIDS in Riverside County and 11 in San Bernardino County. Of the combined 30 transgender cases, 20 were male to female (MTF) and 10 female to male (FTM). To insure confidentiality no further analysis is presented.



Data from: Electronic HIV/AIDS Reporting System (eHARS) 1st quarter, 2013

In Riverside County, white gay, bisexual or other men who have sex with men, carry a disproportionate burden of HIV disease (Figure 39). However, Hispanic and black residents diagnosed with HIV in Riverside County progress to AIDS faster than white residents (Figure 40). On average, Hispanic/Latino and African American persons living with AIDS progressed to that stage of the disease 50% faster than whites.

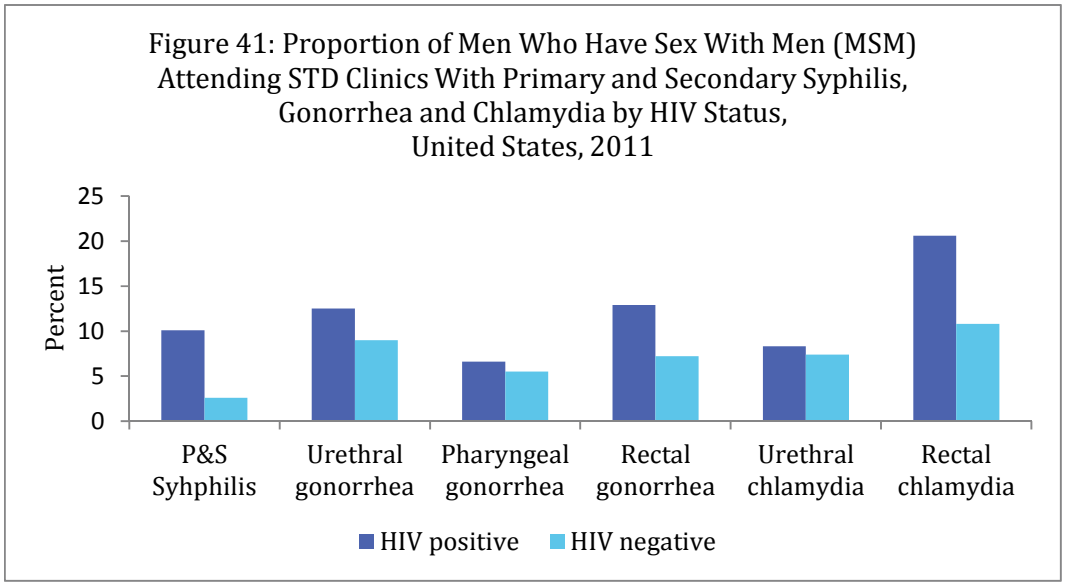


Data from: Electronic HIV/AIDS Reporting System (eHARS) 1st quarter, 2013

Syphilis, Chlamydia, Gonorrhea, Human papilloma virus (HPV)

HIV is not the only sexually transmitted disease (STD) of concern. Similar to the general population, LGBT are susceptible to syphilis, chlamydia, gonorrhea and HPV. These other infections can also increase the risk for acquiring HIV.

When comparing the prevalence of STDs by HIV status in MSM visiting STD clinics, the prevalence was lower among HIV-negative MSM status than among HIV-positive MSM (Figure 41).



CDC 2012b page 83

Syphilis

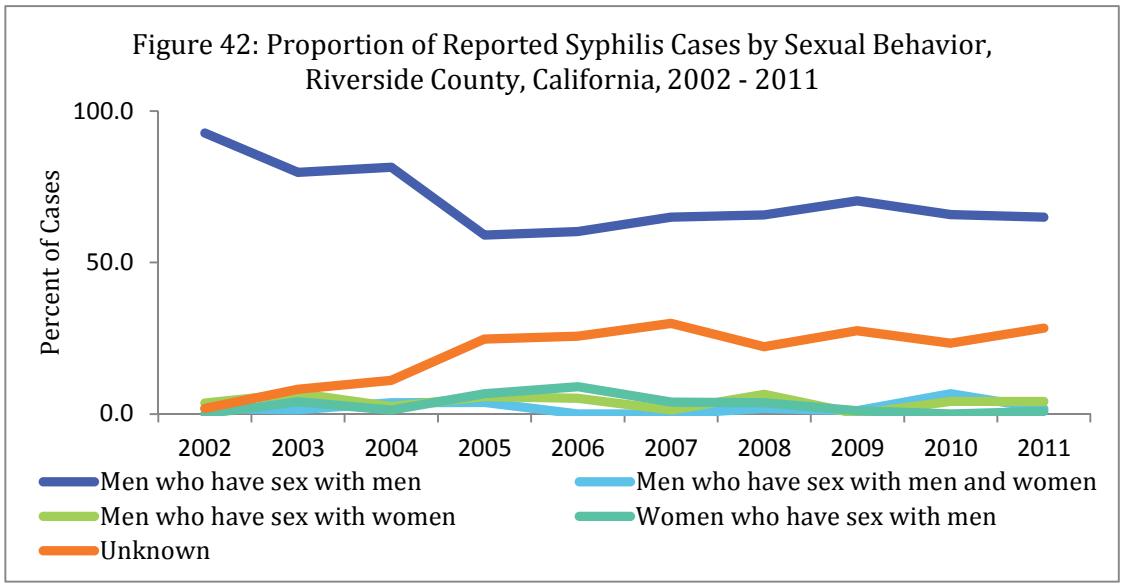
Syphilis continues to be a health concern throughout the nation. Originally considered a hetero-sexual disease the incidence of syphilis has shifted to disproportionately affect gay, bisexual and other men who have sex with men. In 2011, of the 13,136 total cases reported, MSM accounted for 72% of all primary and secondary (P&S) syphilis cases in the United States (Sexually Transmitted Disease Surveillance 2011, Division of STD Prevention, CDC, Dec. 2012).

Table P: 2011 Primary & Secondary Syphilis Rates per 100,000 General Population

	Rate per 100,000 population	Rate per 100,000 male population	Rate per 100,000 female population
United States	4.5	8.2	1.0
California	6.5	11.8	0.5
Riverside County	5.8	10.7	0.3
San Bernardino County	2.9	4.9	0.5

County and State Data Source: California Local Health Jurisdiction STD Data Summaries, 2011 Provisional Data (August 2012), California Department of Public Health.

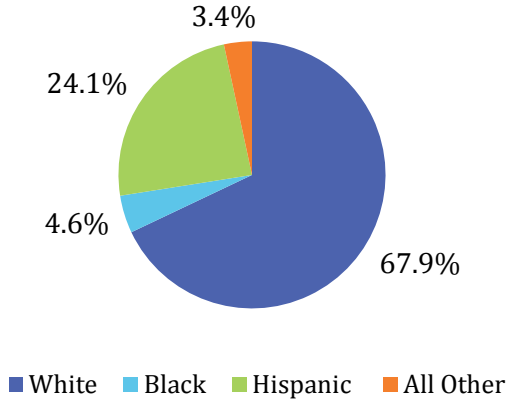
Riverside County has followed the same trend. In 2011, MSM made up 72% of the P&S cases nationwide and 67% of the 129 cases reported in Riverside County (Figure 42). Riverside County is markedly affected by the disease, ranking 25th in the nation out of 3,143 counties (CDC, 2012b).



Over a ten year period in Riverside County (2002-2012) there were 957 reported cases of primary and secondary syphilis with an average of 97 new cases per year. Over this ten year period, the MSM population accounted for 71.4% of all syphilis cases. Most cases (69%) reside in the Coachella Valley region (Palm Springs, Palm Desert, Cathedral City, Indio, and Coachella) of Riverside County. The incidence rates in this region were more than three times higher than the incidence rate for the rest of the county with 14.6 cases per 100,000. This rate is far higher than the Healthy People 2020 objective of 1.4 cases per 100,000 females and 6.8 cases per 100,000 males (Curlee, 2013).

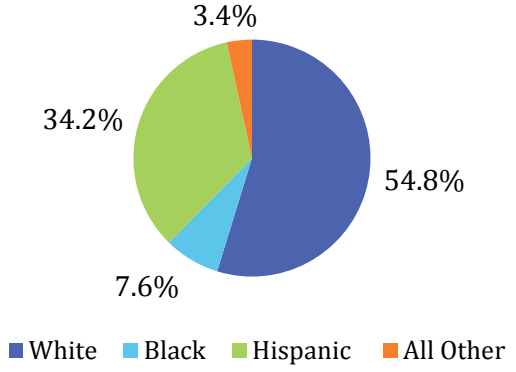
Transgender persons made up less than 10 reported cases from 2002-2012. Further analysis of these cases is not presented here to ensure confidentiality.

Figure 43: MSM Diagnosed With Primary & Secondary Syhilis by Race/Ethnicity, Riverside County, 2002-20012



California Department of Public Health

Figure 44: Non-MSM (Exclusively Heterosexual Men and all Women) Diagnosed with Primary and Secondary Syphilis by Race/Ethnicity, Riverside County, 2002-2012

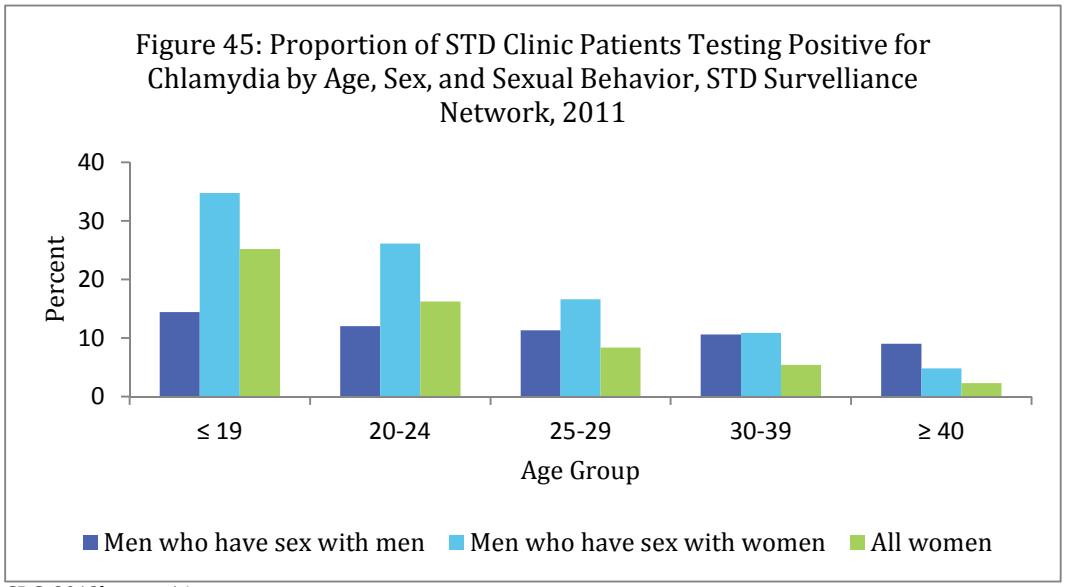


California Department of Public Health

Chlamydia

In 2011, there were slightly more than 1.4 million chlamydia cases reported in the United States and, based on sentinel data from 42 STD clinics in 12 sites across the nation, an estimated 11.3% (159,645) of the cases were among gay, bisexual or other men who have sex with men (CDC, 2012b).

Adolescent men who have sex with women (MSW) had the highest prevalence (34.8%). Among MSW and women, prevalence among those tested decreased with age. The variation in prevalence by age was not as pronounced for men who have sex with men (MSM) (Figure 45).



CDC, 2012b, page 14

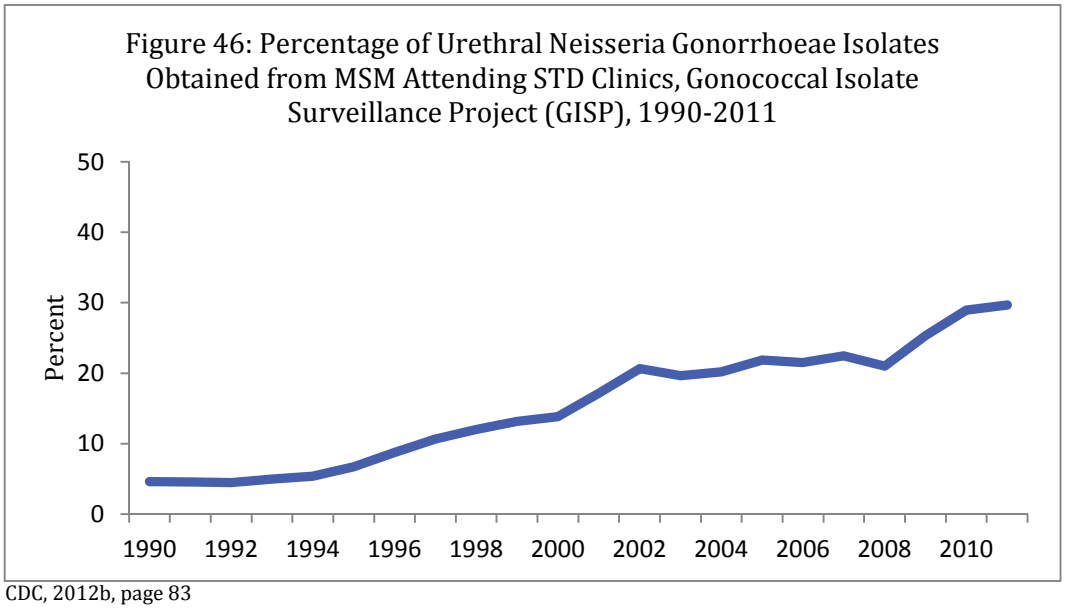
Table Q: Total Chlamydia Cases and Rates per 100,000 General Population, 2011

	Total Cases	Rate per 100,000
United States	1,412,791	457.6
California	166,773	447.7
Riverside County	9,802	447.7
San Bernardino County	10,947	537.9

In 2011, there were 9,802 reported chlamydia cases in Riverside County, a 34% increase over the previous year. There were 2,132 cases identified among men and 6,581 among women. It is unknown how many cases were among sexual minorities in the county (Table Q).

Gonorrhea

Gonorrhea is the second most commonly reported notifiable disease in the United States. In 2011, there were more than 300,000 gonorrhea cases in the United States and based on sentinel data from 42 STD clinics from 12 sites across the nation (Figure 46) an estimated 14.5% of the cases were among gay, bisexual or other men who have sex with men (CDC, 2012b).



CDC, 2012b, page 83

Gonorrhea was the third most frequently reported infectious disease in Riverside County during 2011, with 896 cases reported and an incidence rate of 40.2 cases per 100,000 population. Cases were evenly split between men (456 cases) and women (437 cases). It is unknown how many cases were among sexual minorities in the county.

Human Papillomavirus (HPV)

The Human papillomavirus (HPV) is a common virus that is spread through sexual contact and many of those infected do not know they have it. According to the Centers for Disease Control and Prevention (CDC), some strains of the virus can cause cervical cancer in women and can cause other kinds of cancer like anal cancer in both men and women. Other types can cause genital warts in both males and females. There is a vaccine which prevents the most common types of HPV that cause these cancers and genital warts.

Like cervical cancer, we now know that some strains of the human papillomavirus (HPV) are causally linked to the development of anal cancer, although little is known of its prevalence among gay and bisexual men. Some studies have suggested that prevalence of anal HPV among MSM may be nearly 60% (IOM 2011).

HPV is not a reportable STD; therefore, there is no local data on the incidence or prevalence of this disease.

Hepatitis A, B, C

Hepatitis A, B and C are contagious liver diseases. 2010 estimates by the CDC of new hepatitis A, B, and C infections in the United States are 17,000, 38,000 and 17,000 respectively.

The CDC states that approximately 10% of new hepatitis A and 20% of new hepatitis B infections in the United States are among men who have sex with men. In addition, the CDC has investigated several outbreaks of hepatitis C among HIV positive gay men and just over 10% of hepatitis C cases with a reported risk factor are MSM.

Many men have not been vaccinated against hepatitis A and B, despite the availability of a safe and effective vaccine. The CDC recommends that men who have sex with men (MSM) get vaccinated against viral hepatitis A and B (CDC, 2006a; CDC, 2006b).

Historically, the incidence of hepatitis A peaks every five to seven years. In Riverside County only four hepatitis A cases were reported in 2011.

Summary

Monitoring of health conditions allows for the examination of a community's overall health status and helps to identify disparities in health outcomes between populations. Unfortunately, there is a deficiency of epidemiological information on the LGBT population due to a general lack of data collection.

Chronic Disease:

- LGB reported slightly fewer cases of heart disease than heterosexuals (3.8% vs. 4.3%) while bisexual men (28.2%) reported more cases of high blood pressure over all other men (straight men 23.6% and gay men 20.2%). These differences were not significant but might hint at protective factors (i.e. higher rates of physical activity, see page 37) within the LGB community.
- In California, nearly 1 in 10 lesbians (9.1%), and gay men (8.7%) self-reported a cancer diagnosis compared to 6.2% of heterosexual men and women.
- In California, lesbians and bisexual women 30 years old and older receive mammograms and Pap tests less often than heterosexual women.
- In California, nearly a quarter of all lesbians (24.1%) and bisexual women (24.8%)report having an asthma diagnosis.
- In the Inland Empire, a higher percentage of bisexual men (45%) and women (42.1%) report that they are disabled than heterosexual men and women (27.7% and 30.5%) or gay men and lesbians (30.1% and 22.4%). This disparity is seen throughout the state.
- In California and the Inland Empire, more gay men feel they are in very good or excellent health than other sexual orientations while the reverse is true for bisexual women.

Communicable Disease:

- In Riverside County, 85% of all people who are currently living with HIV or AIDS are gay, bisexual or other men who have sex with men.
- Since 2002, 75.5% of all new HIV infections in Riverside County have been through unsafe sex among gay, bisexual or other men who have sex with men.
- Since 2002, 71.4% of all syphilis cases have been among gay, bisexual or other men who have sex with men.

Health Care Access

Health care access can be reflective of such things as ability to pay, transportation, geography, delivery of competent care, patient perceptions, and institutional barriers such as discriminatory laws and policies. A person's access to good quality care can affect their health outcomes.

Disparities in healthcare access exist between the LGBT and heterosexual communities. Recent studies have indicated lesbian and bisexual women to be significantly less likely to have health insurance coverage, less likely to have had a checkup within the past year, more likely to report unmet medical needs, and were less likely to have had a recent mammogram or Pap test when compared to heterosexual women. Though results have been mixed, studies of gay and bisexual men have also indicated lower insurance coverage and increased delay of medical care as compared to heterosexuals (Buchmueller and Carpenter 2010; Heck et al. 2006; Wheldon & Kirby 2013). Recent surveys of transgender individuals indicate that many of these issues are not only present, but the disparities are even greater for this population (e.g. When Health Care Isn't Caring, 2010).

This section will review insurance coverage, culturally competent care, delay of care and structural barriers to health access for lesbian, gay, bisexual and transgender populations at the National, State and local level.

National Picture

The Institute of Medicine, American Public Health Association, American Medical Association and many other health professional organizations have recognized the need to address LGBT health disparities (Corliss et al., 2007; Dean et al., 2000; IOM, 2011). As a first step, healthcare providers need to know what to do when presented with an LGBT patient, in other words, to provide culturally and medically appropriate care and information to their LGBT patients. Unfortunately, few of the country's medical schools and schools of public health adequately prepare health professionals to properly care for LGBT patients or populations. Even at schools that have begun to more actively address LGBT health issues, training hours dedicated specifically to this topic are often insufficient (IOM, 2011). For example, in one national survey of schools of public health "fewer than 9% of the departments had offered a course in the past 2 years that covered lesbian, gay, bisexual, or transgender health topics extending beyond HIV and AIDS" (Corliss et al., 2007). Further, Obedin-Maliver and colleagues (2011) found that the median time spent on lesbian, gay, bisexual, and transgender-related content in medical education in the U.S. and Canada was only 5 hours total.

Perceptions of discrimination and whether one can access quality health services have been shown to not only affect whether and how individuals seek medical care and interact with medical professionals but affect health outcomes as well (Harcourt, 2006; When Health Care Isn't Caring, 2010). A health professional's level of knowledge about LGBT health issues and their LGBT cultural competency can have a large effect on a person's decision to disclose sexual or gender minority status (i.e., "come out") to health providers or whether or not to even obtain services in the first place (Movement Advancement Project, 2010; Bonvicini & Perlin, 2003). This is part of the lifelong process of coming out (de Vries & Blando, 2004) with potential and significant costs to health and well-being (e.g., Meyer, 2003). Calculations of perceived safety and comfort used in deciding when, what, and how much to reveal about LGBT status can be particularly acute for the youngest and oldest LGBT persons and LGBT persons of color.

Table R: Rates of Nondisclosure of Sexual Orientation Among Lesbian, Gay and Bisexual Men and Women within Interpersonal Relationships

	Women (% not out)		Men (% not out)	
	Lesbian	Bisexual	Gay	Bisexual
Healthcare providers	12.9	32.6	10.0	39.3
Family	5.2	25.6	8.8	21.4
Straight friends	1.9	9.3	5.9	21.4
LGB friends	0.0	0.0	0.0	3.6
Co-workers	13.5	48.8	11.2	42.9

Durso, 2013

The above referenced study of New York LGB (Table R) showed that, compared to those identifying as lesbian or gay, bisexuals are far less likely to be "out" to their health care providers.

Pervasive ignorance about gay, lesbian, bisexual and transgender health issues and a lack of cultural competence on the part of providers, combined with perceived danger or discomfort on the part of LGBT patients, are factors that contribute to many LGBT not accessing medical care with the same frequency as their heterosexual counterparts (Movement Advancement Project, 2010). This anticipated stigma and discrimination (e.g., MetLife, 2010) may lead to deferred or delayed health care utilization with missed opportunities for preventive intervention (Bonvicini & Perlin, 2003).

Table S: Percent of Survey Respondents Reporting Perceived Discrimination in Healthcare

Question	LGB	Transgender
Health care professionals refused to touch me or used excessive precautions	10.6	15.4
Health care professionals blamed me for my health status	12.2	20.3
I was refused needed health care	7.7	26.7
Health care professionals used harsh or abusive language	10.7	20.9

When Health Care Isn't Caring, 2010

Even after the U.S. Supreme Court's historic ruling striking down Section 3 of the Defense of Marriage Act (DOMA) there are still significant institutional barriers that prevent many LGBT across the country from equal access to the healthcare system (GAO 2004).

In 33 states across the U.S., it continues to be legal to fire or deny employment to someone simply for their sexual or gender minority status (www.lambdalegal.org) and, in most cases across the nation, employers are not legally compelled to offer benefits to the same-sex partners of their LGBT employees. Given that 71% of all those with insurance in the United States are insured through their, or a family member's, employer (Census.gov), barriers to employment and domestic partner/marriage benefits can greatly restrict LGBT persons' access to healthcare.

Examples of institutional barriers to care:

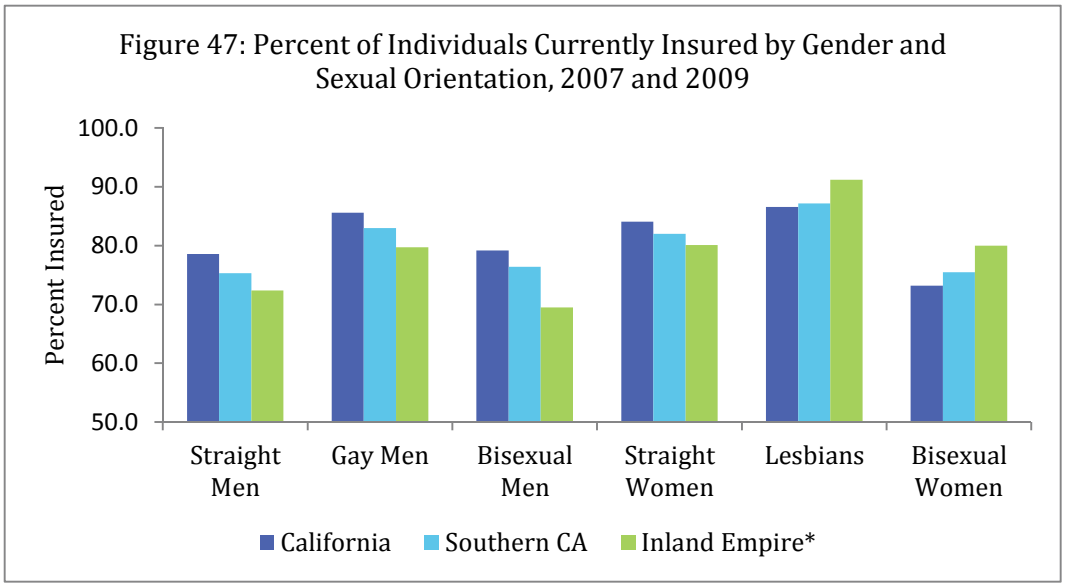
- **Employment discrimination**: Though illegal in California, it is still legal in 33 states to fire or not hire someone for their sexual orientation or gender identity.
- **Medical discrimination**: Though illegal in California, in many states it is legal, though unethical (American Medical Association policy E-9.12), for medical providers to refuse care to LGBT patients.
    - In 28 states it is legal to refuse medical care based on sexual orientation.
    - In 36 states it is legal to refuse medical care based on gender identity.

In recent years a myriad of California state laws (e.g. the Unruh Civil Rights Act; California's Fair Employment and Housing Act; the Domestic Partner Rights and Responsibilities Act; the Older Californians Equality and Protection Act; California Code Section 11135; School Success and Opportunity Act) have removed many state level structural barriers to LGBT social and health equity. While these have all been positive advances in protections for LGBT individuals, state laws do not apply to federal programs and do not protect individuals when traveling outside of California.

Further, Riverside County LGBT residents and visitors may have experienced structural/ institutional discrimination in the past or in other states bringing those experiences with them when needing to access care in Riverside County.

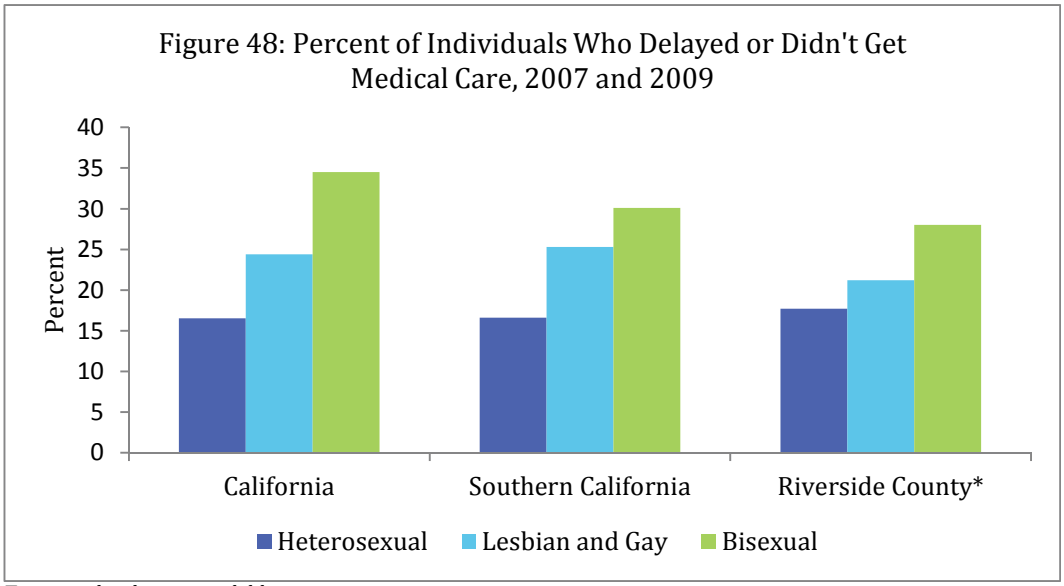
Local Picture

Local data reveals that unlike many other parts of the country more California and Riverside County gay men and lesbians report being currently insured than their heterosexual or bisexual counterparts (Figure 47). A higher percentage of that coverage is through privately purchased insurance plans rather than public or employment-based plans (CHIS 2007 and 2009).



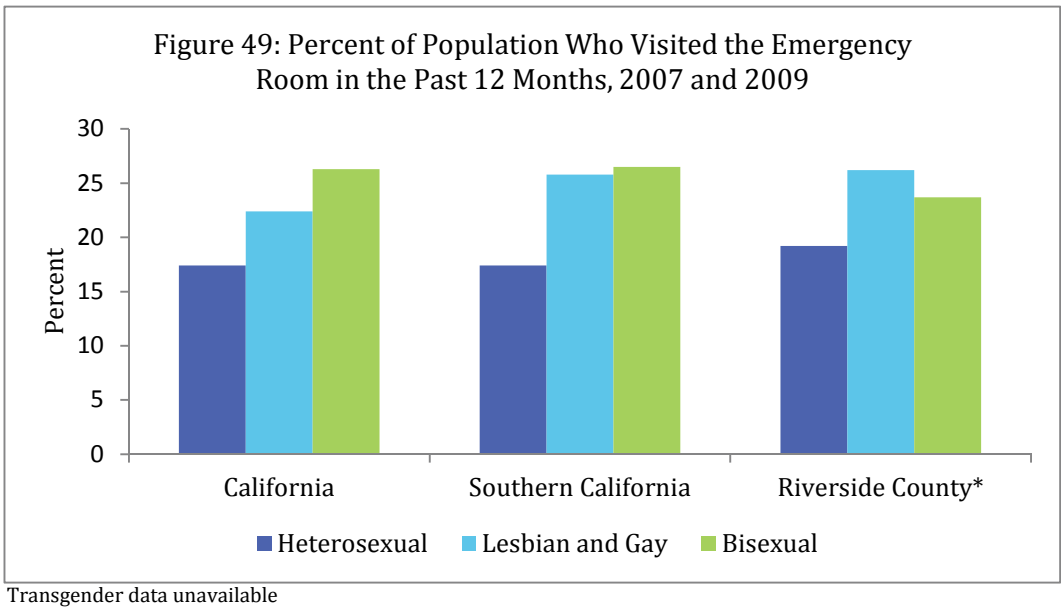
Transgender data unavailable

Though insured at higher rates, both emergency department visits and delay of needed care are reported among gay men, lesbians and bisexual men and women at higher rates than the general population (Figures 48—49). This may indicate reluctance for Riverside County lesbian, gay, and bisexual residents to interact with healthcare professionals.

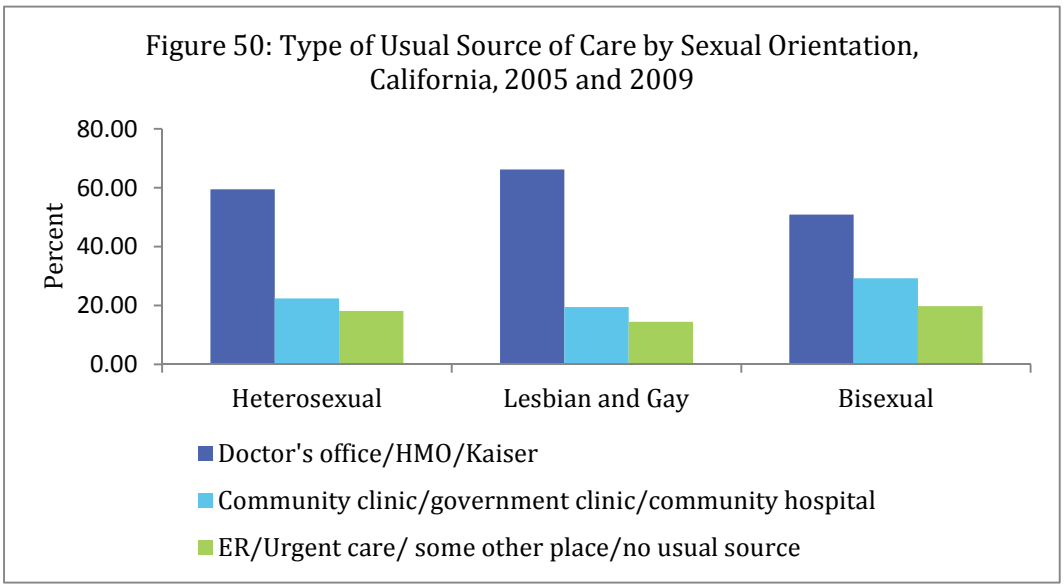


Transgender data unavailable

Across California, bisexuals are 30% more likely to receive their usual health care from a community or government clinic or hospital (Figure 50). This has important implications for healthcare professionals in those settings. This reliance on community clinics is not surprising given the lower economic status of many bisexuals (see pages 21-22).



Transgender data unavailable



Transgender data unavailable

A 2008 study of older LGBT residents in Riverside County found that almost one-third of midlife and older gay men and lesbians maintain some fear of openly disclosing their sexual orientation. Similarly, older gay men and lesbians maintain some discomfort in their use of older adult social services with the majority reporting that they would feel more comfortable accessing LGBT-friendly identified services and programs. This data supports prior research on the apprehension of LGBT elders in accessing care and the crucial role of acceptance (Gardner et al., 2013).

One source for locating medical professionals with an interest in serving the LGBT population is through the Gay and Lesbian Medical Association's (GLMA) provider directory. Unfortunately, there are currently only four healthcare professionals (two physicians) listed for Riverside County (www.glma.org accessed 12/18/2013).

Summary

Access to good quality, culturally competent healthcare accounts for a critical 10 - 15% of a community's overall health outcomes.

- In general, more California women (87.9%) have health insurance than men (84.4%) and gay men (85.1%) are insured at greater rates than straight men (78.6%).
- Though insured at greater rates, higher percentages of LGB report delaying medical care or using emergency department services than their heterosexual peers.
- In California, bisexual men and women report that they are more likely to use community clinics or emergency departments for their usual source of care than other sexual orientations.

Mental Health

Mental health disorders affect a substantial proportion of the local, state and national population. According to the National Institute of Mental Health (www.nimh.nih.gov), nearly 30% of adults meet criteria for anxiety disorder and nearly 21% for a mood disorder over their lifetime. In comparison, LGB populations have been shown to have significantly elevated rates of mood and anxiety disorders over their straight counterparts (see Table T). In order to design and implement appropriate prevention and intervention programs it is critical to understand which groups are at disproportionate risk for mental health disorders and why (Bostwick, 2010).

Table T: Lifetime Prevalence of Mood and Anxiety Disorders by Sexual Identity, United States, 2004-2005

	Sexual Identity					
	Gay Men	Bisexual Men	Straight Men	Lesbian	Bisexual Women	Straight Women
Any mood disorder	42.3%	36.9%	19.8%	44.4%	58.7%	30.5%
Any anxiety disorder	41.2%	38.7%	18.6%	40.8%	57.8%	31.3%

Adapted from Bostwick et al., 2010

Societal discrimination has a direct impact on the mental health of LGBT men and women. A social context of oppression leads to social and family alienation, reduced levels of social support, low self-esteem, and symptoms of psychological distress. For racial/ethnic minority LGBT the social impact on mental health is amplified due to the intersection of racism and heterosexism (Hatzenbuehler 2010).

Hatzenbuehler and colleagues (2010), studying the impact of institutional discrimination such as bans on marriage equality on the mental health of LGB populations, found that the prevalence of mood, anxiety and substance use disorders increased in states enacting such bans and decreased in states that did not. They conclude "living in states with discriminatory policies may have pernicious consequences for the mental health of LGB populations." Other studies have highlighted the detrimental effects of discrimination on health (McLaughlin et al, 2010; Diaz et al, 2001; Lick et al., 2013).

In another study examining the impact of homophobia, poverty and racism on the mental health of Latino gay and bisexual men Diaz et al (2001) found high prevalence rates of psychological symptoms of distress including suicidal ideation (17%), anxiety (44%), and depressed mood (80%).

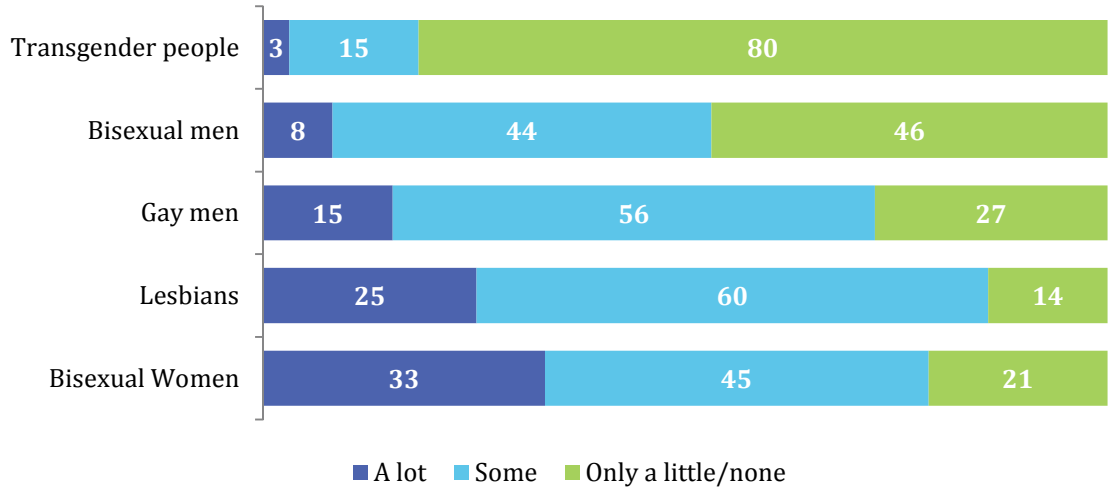
This section will focus on social support, psychological distress, and completed and attempted suicide among LGBT populations.

Social Support and Perceived Social Acceptance

Research has established a link between perceived social support and acceptance and health-related quality of life (Meyer, 1995; Bekele et al, 2013; Cadzow & Servoss, 2009; CDC, 2005). In the June 2013 report on LGBT Americans the Pew Research Center showed that only 19% of LGBT adults say there is "a lot" of social acceptance of lesbian, gay, bisexual and transgender people in the United States and 53% say there is a lot of discrimination against these groups (Figure 51). Further, significant percentages of LGBT adults report having been treated unfairly because of their sexual orientation or gender identity. Experiences ranged from poor service in restaurants and hotels to threats and physical attacks.

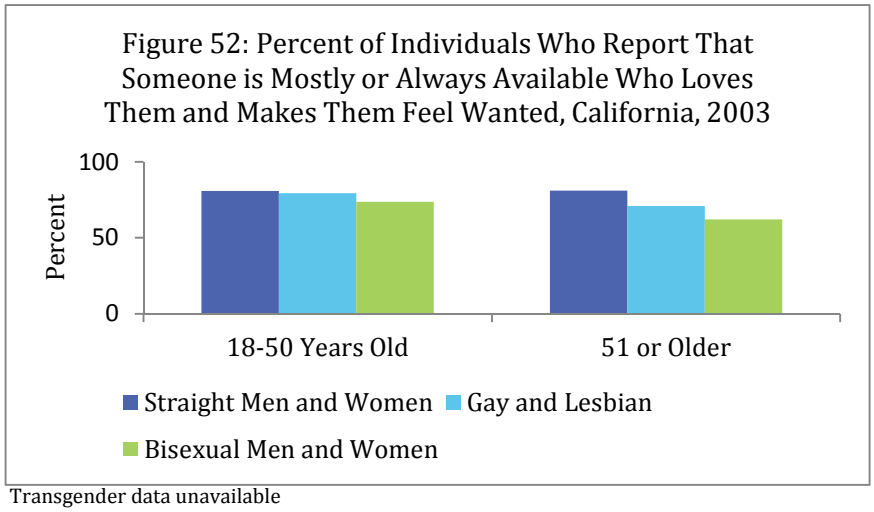
Among the Pew survey respondents, whites were more likely than non-whites to say society is a lot more accepting of LGBT adults now than it was a decade ago (58% vs. 42%). Non-whites are more likely than whites to say being LGBT is extremely or very important to their overall identity (44% versus 34%) and more likely as well to say there is a conflict between their religion and their sexual orientation (37% vs. 20%).

Figure 54: LGBT Perceived Social Acceptance for Each Group, 2013
"% of all LGBT saying there is ... acceptance for each group"

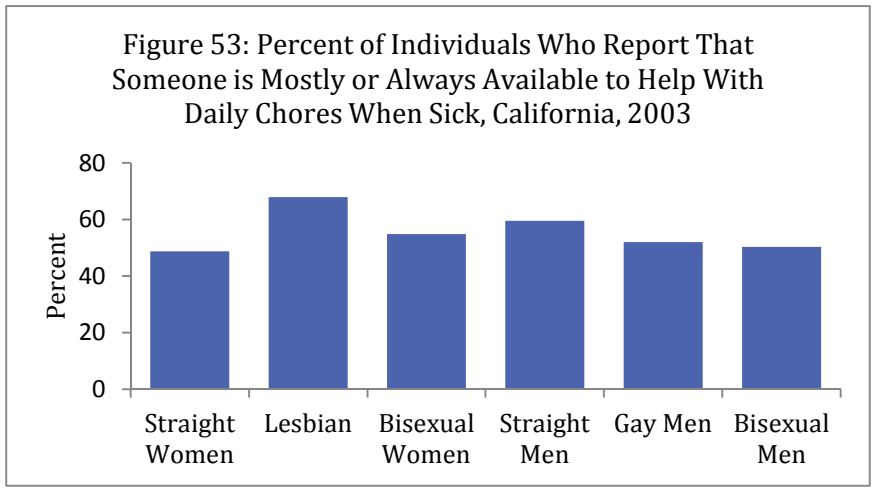


Pew Research Center *A Survey of LGBT Americans: Attitudes, Experiences and Values in Changing Times,*

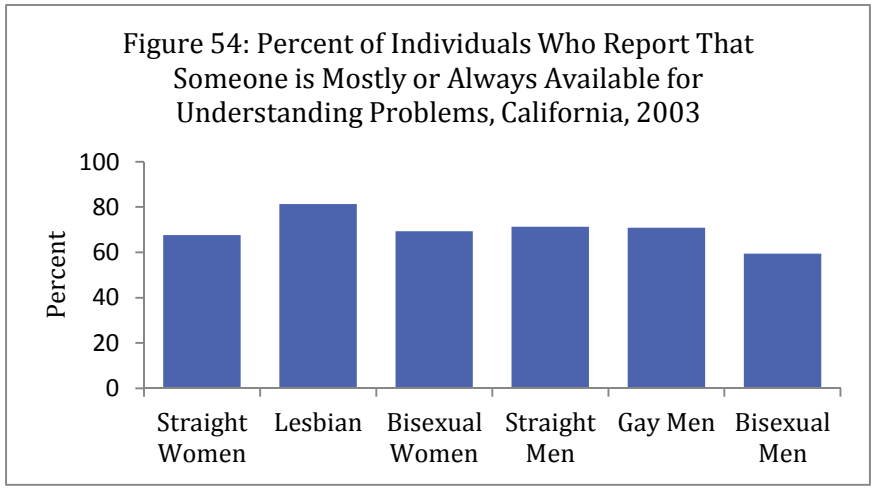
Indicators of social support are having someone who makes you feel loved or wanted, support when sick and having someone who understands your problems. California heterosexuals 50 years old and younger report having someone who loves them and makes them feel wanted at a greater rate than lesbians, gay men and bisexuals of the same age group (80.7% vs 75.3%), a difference which increases for those over 50 years old (Figure 52). More lesbians than hetero-sexual women report having someone available to help with chores when sick (67.9% vs. 48.7%) while fewer gay men report the same compared to straight men (52% vs. 59.5%) (Figure 53). For those reporting the availability of someone who is available for understanding problems more lesbians report having someone (81.4%) then straight women (67.6%) and more straight men (71.3%) than bisexual men (59.5%) reported having someone (Figure 54). Though not shown here due to low sample sizes the Inland Empire trend is similar.



Transgender data unavailable



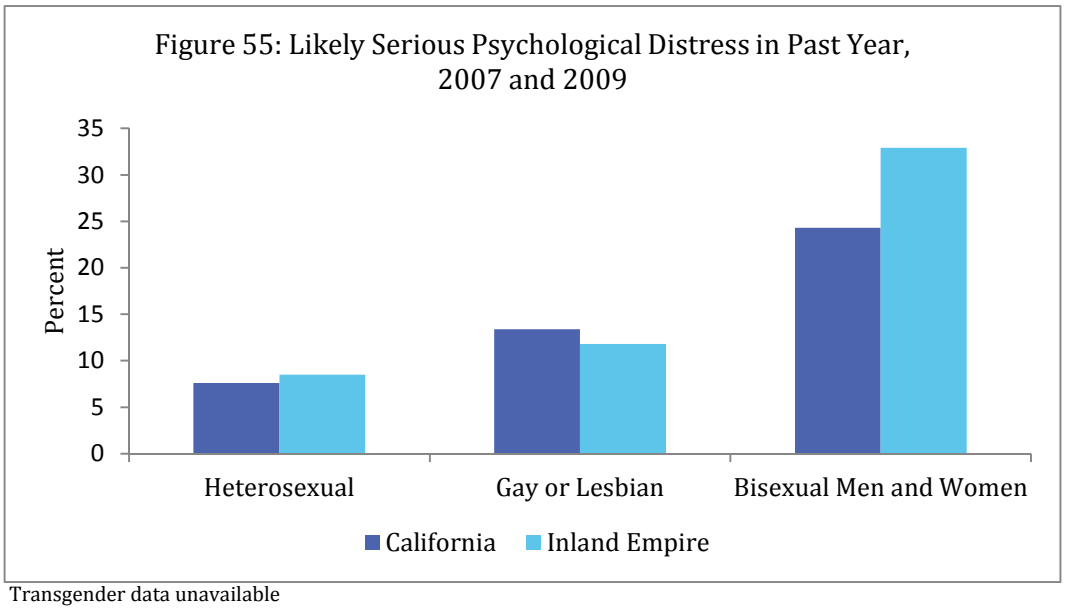
Transgender data unavailable



Transgender data unavailable

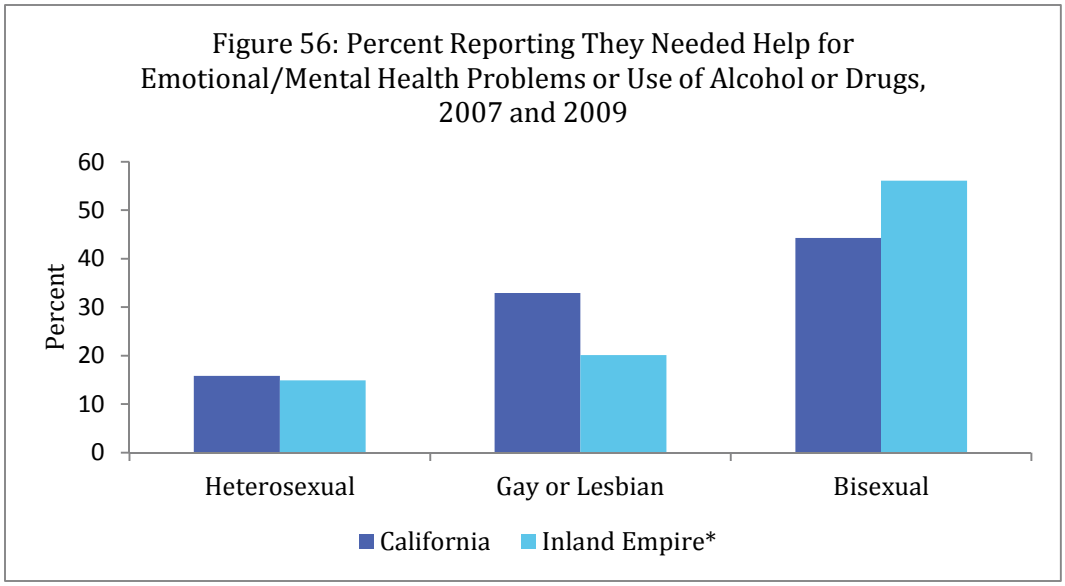
Psychological Distress

There are a number of socio-environmental risk factors which can increase a population's level of serious psychosocial distress. One method to understand the mental health of populations is to look at the amount of serious psychological distress reported by members of those populations. As seen in Figure 55 in both California and the Inland Empire, LGB populations report suffering from psychological distress at greater rates than the straight population, with bisexuals suffering psychological distress more than four times the rate of the straight population.

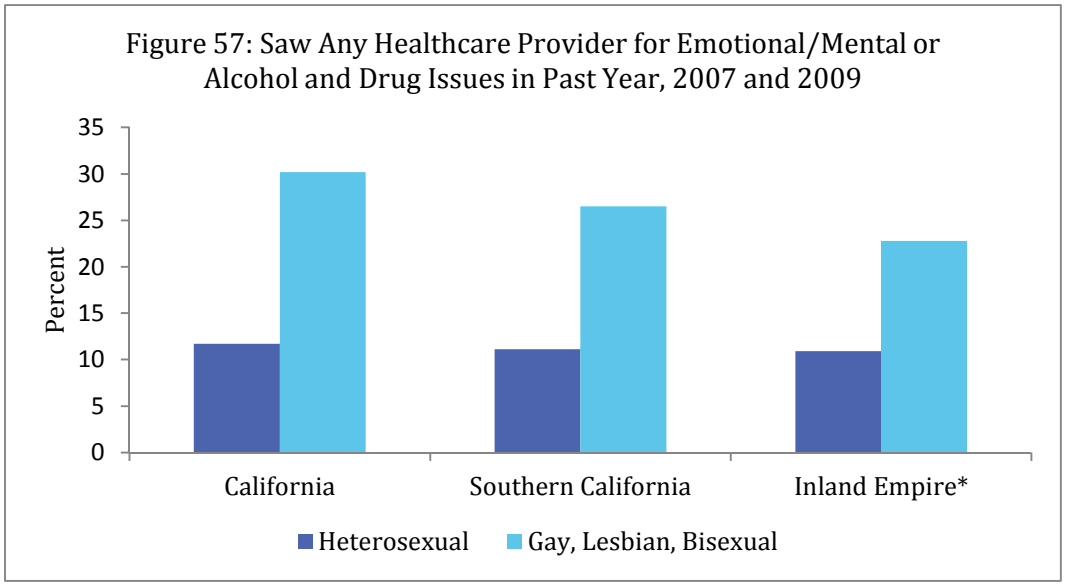


Transgender data unavailable

In the case of happiness, just 18% of LGBT adults describe themselves as "very happy," compared with 30% of adults in the general public who say the same. Gay men, lesbians and bisexuals are roughly equal in their expressed level of happiness (PEW 2013).



Transgender data unavailable



Transgender data unavailable

In California and the Inland Empire, gay, lesbian and bisexual respondents to the California Health Interview Survey report needing help for emotional or substance use problems at two to three times the rate of heterosexuals (Figure 56). Across California, gay, lesbian and bisexual men and women report seeking healthcare for emotional issues at twice the rate of straight men and women (Figure 57). Bisexual, gay and lesbian residents are more likely to feel they need help but are also more likely to seek help from a healthcare provider than their heterosexual peers.

Suicide

National Picture

Suicide is the tenth leading cause of death in the United States. An estimated 1 million adults (0.5% of the U.S. adult population) reported making a suicide attempt in the past year (CDC, 2012). A complex behavior with multiple risk factors, attempted suicide rates are considerably higher among LGBT populations than among heterosexual/gender-conforming populations (IOM, 2011; Clements-Nolle, 2006). Known risk factors in the general population include depressive symptoms, substance abuse, and physical and sexual abuse. For LGBT populations, sexual orientation and gender discrimination and victimization have also been shown to be significantly associated with attempted suicide (Hatzenbuehler, 2011; IOM, 2011; Clements-Nolle, 2006; O'Donnell et al., 2011).

Table U: Estimated Rates of Lifetime Attempted Suicide by Sexual Orientation and Gender Identity, United States.

Population	Percent
Heterosexual & Gender Conforming	0.4 - 5.1
Gay, Lesbian or Bisexual	10 - 40
Transgender Men & Women	26 - 41

Testa et al 2012; Clements-Nolle 2006; CDC 2012; O'Donnell, 2011; Grant 2011

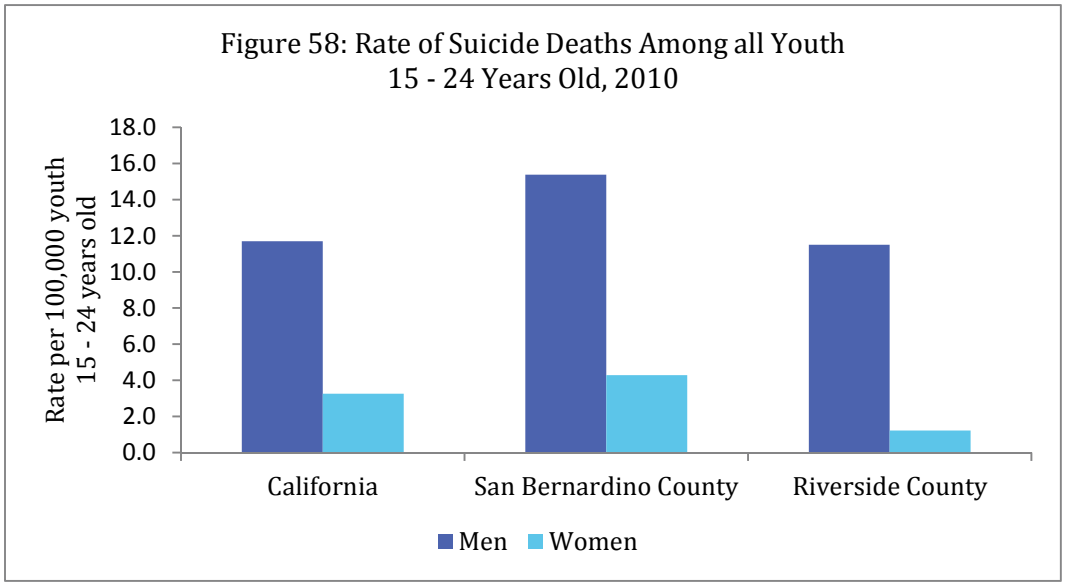
Overall, suicide is the third leading cause of death among all youth aged 15–24 years (cdc.gov WISQARS). Evidence indicates that LGB youth may be two to five times more likely to attempt suicide compared with straight youth. This is a finding consistent across many state, national and international studies (IOM, 2011).

There are a number of individual and social-environmental risk factors, shown to raise the risk of suicide attempts among LGB youth. Individual-level risk factors include depressive symptoms, alcohol abuse, peer victimization, and physical abuse by an adult. Social-environmental factors encompass such things as a lack of same-sex couples living in an area, unsupportive voting patterns, lack of schools with gay-straight alliances, lack of anti-bullying policies specifically protecting LGB students and a lack of schools with antidiscrimination policies that includes sexual orientation. These social-environmental factors have been demonstrated to increase the likelihood of suicide attempts among LGB students by as much as 20% (Hatzenbuehler, 2011; IOM, 2011).

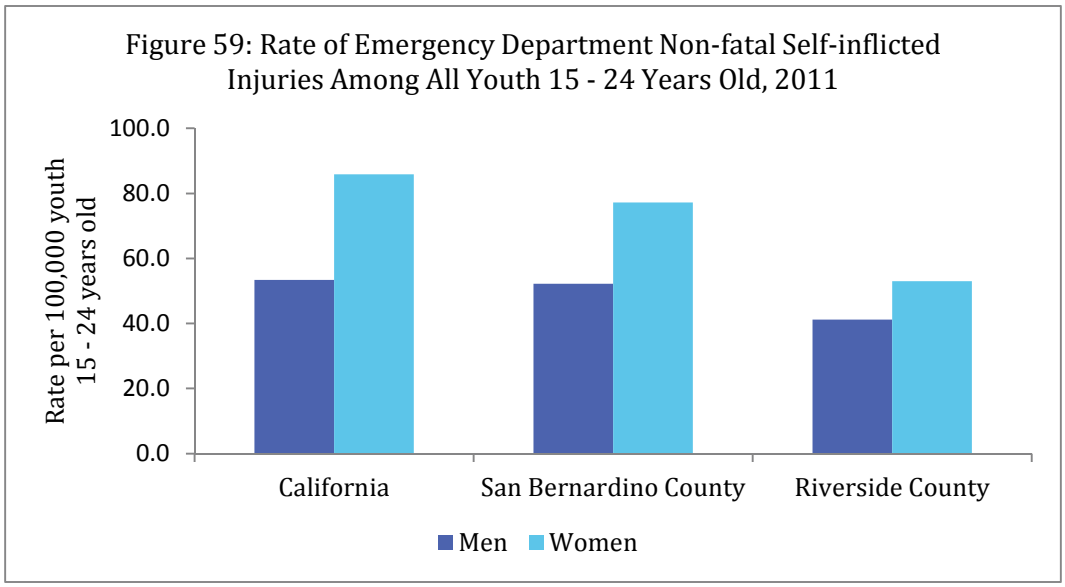
Local Picture

It should be noted that data on suicide behavior has limitations. There is no national standard for capturing this data and often a person's intent is unknown. Comparing suicide behaviors across different jurisdictions should be done with caution (SPRC, 2003).

Over the past ten years, an average of twenty-five Riverside County youth 15 – 24 years old died from suicide annually. Locally, it is unknown how many suicides are initiated by LGBT youth.

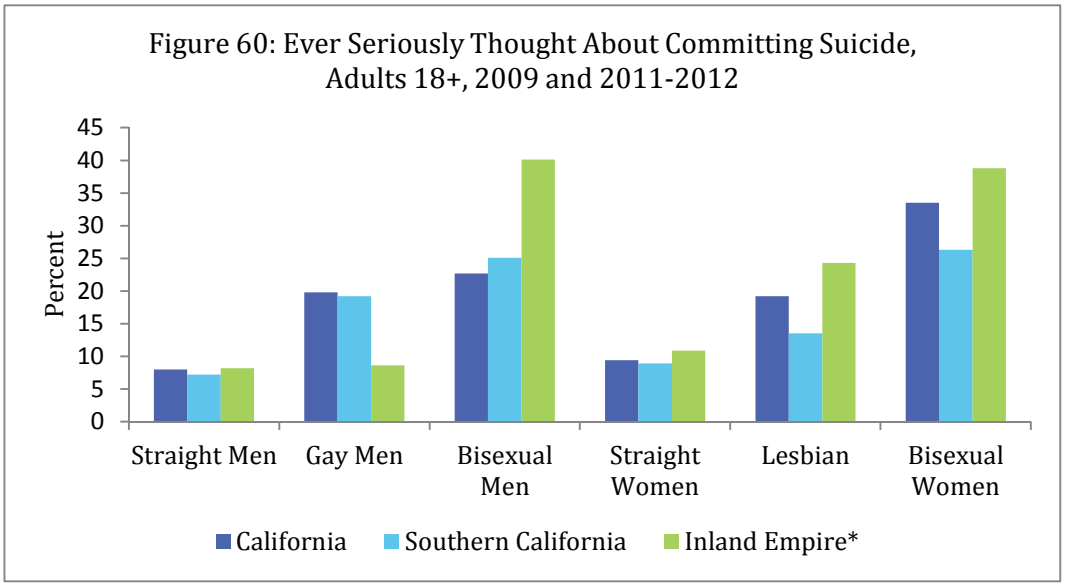


Data generated from http://epicenter.cdph.ca.gov on: May 30, 2013
LGBT data unavailable



Data generated from http://epicenter.cdph.ca.gov on: May 30, 2013
LGBT data unavailable

As seen in Figure 60, California lesbian, gay, and bisexual adults 18 years and older reported ever seriously thinking about suicide at rates 2.5 to 4 times higher than their heterosexual counterparts. Though rates for the Inland Empire are unstable, lesbian and bisexual rates trend similarly to the state. Overall, Inland Empire bisexual and lesbian women reported higher rates of ever thinking about committing suicide when comparing them to their heterosexual counterparts. This trend was also visible when rate comparisons where made between bisexual and straight men. Lastly, similar report rates were observed when gay men and straight men were compared. Organizations devoted to preventing suicide incidence would benefit from improved data collection on LGBT and suicide rates. This would then guide suicide prevention interventions.



Transgender data unavailable

Summary

Good mental health is a critical component of a community's overall wellbeing and impacts all facets of a person's life including their physical health.

Social Support

- In California, fewer LGB report having someone available who loves them and makes them feel wanted than heterosexuals (75.3% vs. 80.7%).
- In California, lesbians (67.9%) report the highest percentage of having someone available to help them when sick while straight women and gay men report the lowest (48.7% and 52.0%).
- In California, lesbians (81.4%) report the highest percentage of people who have someone available for understanding problems while bisexual men report the least (59.5%).
- Local data on transgender populations was unavailable.

Psychological Distress

- In California, gay men and lesbians (13.4%) experience likely psychological distress at nearly double and bisexuals (24.3%) over three times the rate of heterosexuals (7.6%). In the Inland Empire the trend is similar.
- Local data on transgender populations was unavailable.

Suicide

- In Riverside County, an average of twenty-five youth, between 15 and 24 years old, die from suicide each year.
- In 2010, 643 young men and women between 15 and 24 years old were admitted to emergency departments for self-inflicted injuries.
- Throughout California, two to four times more lesbian, gay and bisexual adults report having seriously thought about suicide than heterosexuals.
- Local data on transgender populations was unavailable.

Violence, Assault and Harassment

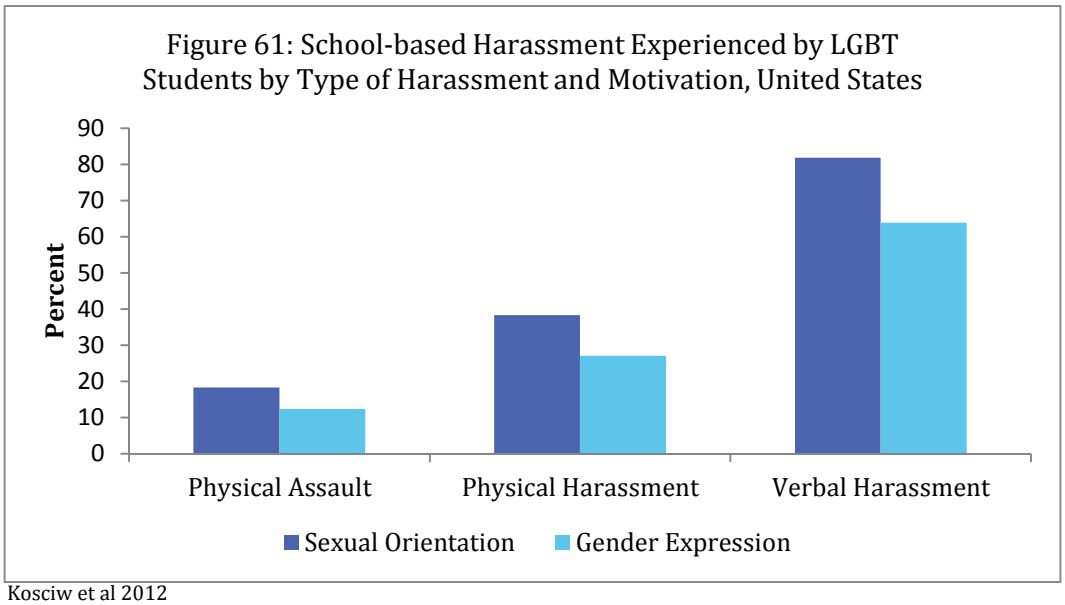
Violence and fear of violence can worsen health outcomes and exacerbate health disparities. Victims of abuse and violence are at an increased risk for many negative health and social outcomes such as anxiety, substance use, depression, low self-esteem, chronic health conditions, academic failure, incarceration and poverty (Garofalo & Bush, 2008; UNITY, May 2011; UNITY, September 2011). Research indicates that LGBT youth and adults experience higher rates of physical, verbal, sexual, and psychological/ emotional abuse and intimidation than their heterosexual/gender-conforming peers. Unfortunately, much like other health domains, data on this issue is limited. For example, the National Crime Victimization Survey, the federal survey on violence in the U.S., contains no questions on sexual orientation or gender identity creating barriers to population based research. Using the limited data that is available the following section will discuss school based violence, hate crimes and intimate partner violence among LGBT populations.

School Based Violence, Assault and Harassment

LGBT youth report higher rates of experiencing verbal, physical, and sexual harassment and violence than their heterosexual peers. In-school victimization is associated with harmful effects on psychological well-being and academic achievement (Kosciew et al, 2013).

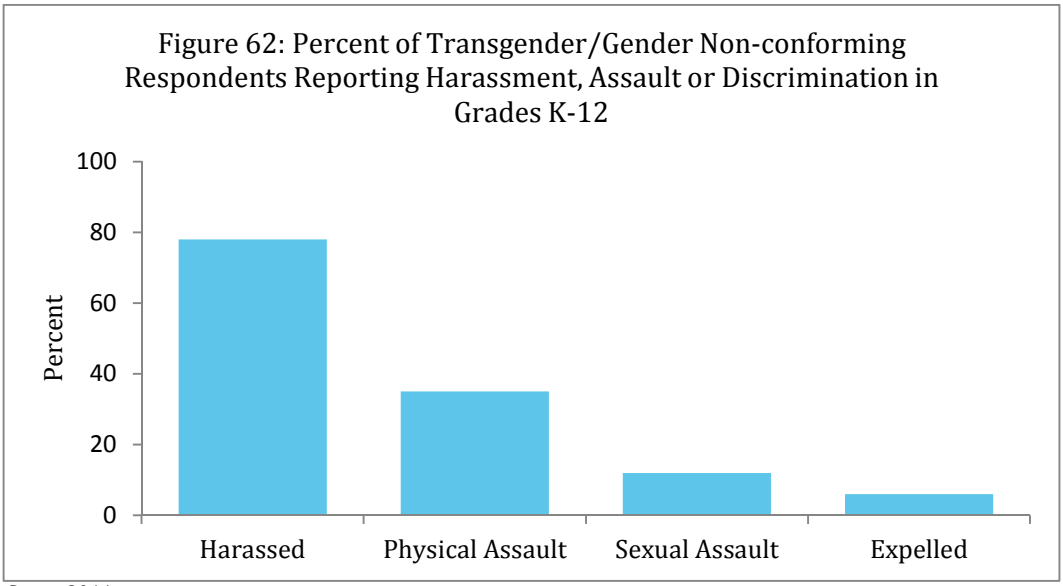
School-based protective factors include educators supportive of LGBT students, the presence of gay-straight alliance clubs (GSAs) (see page 86), anti-bullying/harassment policies that provide specific protections regarding sexual orientation and gender identity, and LGBT-inclusive curricula. These factors have been shown to increase feelings of school safety, lower rates of victimization, and a greater sense of school belonging. These institutional supports are also shown to improve overall psychological well-being and improve academic achievement (Kosciw et al, 2013).

National Picture



Kosciw et al 2012

In *The 2011 National School Climate Survey* 81.9% of public school LGBT students reported being verbally harassed because of their sexual orientation, 38.3% reported being physically harassed, and 18.3% reported being physically assaulted. Not surprisingly, 31.8% of the LGBT students surveyed reported missing a day of school in the past month because of feeling unsafe, compared with only 4.5% of a national sample of secondary students (IOM, 2011; Kosciw et al 2012).



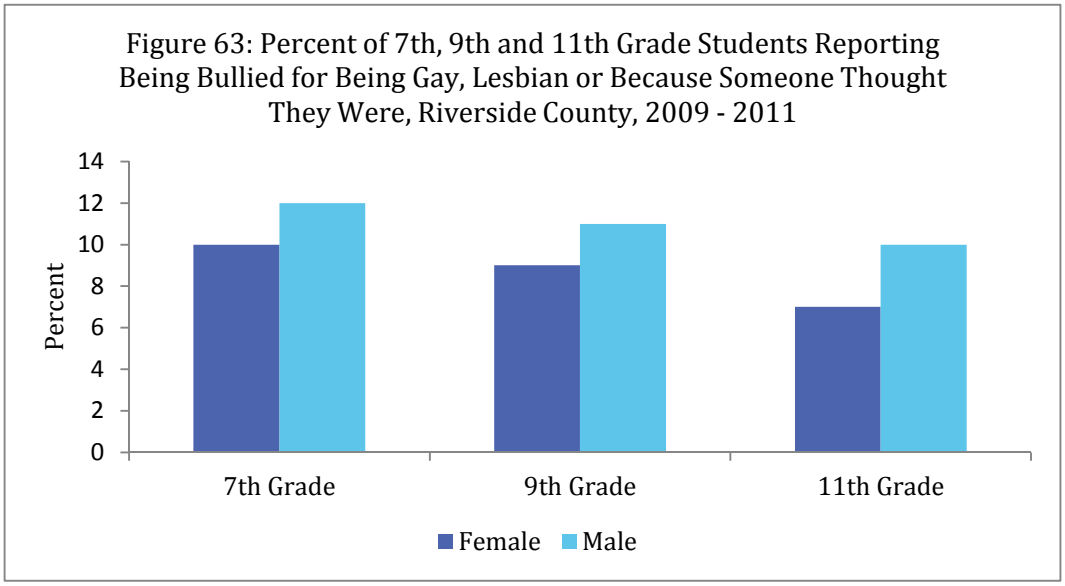
Grant, 2011

Image Courtesy of Stockvault.net

Local Picture

In Riverside County, 11% of 7th grade students, 10% of 9th grade students and 8% of 11th grade students report harassment based on actual or perceived sexual orientation.

Data on gender expression is not available.



Data from: County of Riverside. *California Healthy Kids Survey, 2009-11: Main Report* San Francisco: WestEd Health and Human Development Program for the California Department of Education.

Schools with Gay-Straight Alliance (GSA) clubs have been shown to reduce rates of smoking, drinking, truancy, suicide attempts, sex with casual partners, psychological distress and possibly reduce victimization, increase feelings of school belonging and feelings of student empowerment. Though the positive effects are larger among LGBT students recent studies indicate that these benefits are also experienced by the general school population as well (Poteat et al, 2013; Heck et al, 2011; Russell, et al, 2009; Goodenow et al, 2006).

According to the Gay, Lesbian and Straight Education Network (GLSEN), over half (39 of 60 high schools) of Riverside County's 60 public high schools have GSAs while less than 8% of public middle schools (6 of 80 middle schools) have a GSA (www.glsen.org).

In 2013, the University of California Riverside was named one of the nations top 25 LGBT-friendly universities and colleges by Campus Pride (French, 2013).

Hate Crimes & Violence

The Matthew Shepard and James Byrd, Jr. Hate Crimes Prevention Act, enacted in 2009, expanded federal hate crime law to allow federal prosecution of crimes motivated by a victim's sexual orientation and gender identity. Nationally, 20.8% of all hate crime incidents in 2011 resulted from sexual-orientation bias (FBI, Hate Crime Statistics 2011). The FBI's Uniform Crime Reporting Program began collecting anti-transgender/anti-gender non-conforming hate crime events in January 2013 and national data is not currently available for this population. In California, hate crimes with a sexual orientation bias were the second most common type of hate crime reported in 2011.

Table V: Anti-LGBT Hate Crime Events by Bias Motivation, 2002-2011, California

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
All Hate Crimes	1,659	1,491	1,409	1,397	1,306	1,426	1,397	1,100	1,107	1,060
Anti-Gay	267	218	188	161	163	132	154	120	107	103
Anti-Lesbian	40	47	37	40	23	26	22	29	30	25
Anti-Homosexual	57	71	36	49	57	101	102	95	136	111
Anti-Bisexual	0	1	1	4	3	2	2	1	3	3
Anti-Transgender	9	15	15	13	8	23	13	10	11	11

Hate Crime in California, 2011, California Department of Justice

Many hate crime victims are hesitant to report incidents to police. For example, 30% of respondents to a 2013 Pew Research Center national survey of LGBT people reported having been physically attacked or threatened in their lifetime. In 2011, the Los Angeles Gay & Lesbian Center's Anti-Violence Project was contacted by 515 survivors of anti-LGBT hate violence. This is more than double the official statewide reporting of anti-LGBT hate crime events that year and is another indicator of possible under-reporting (NCAVP, 2012b).

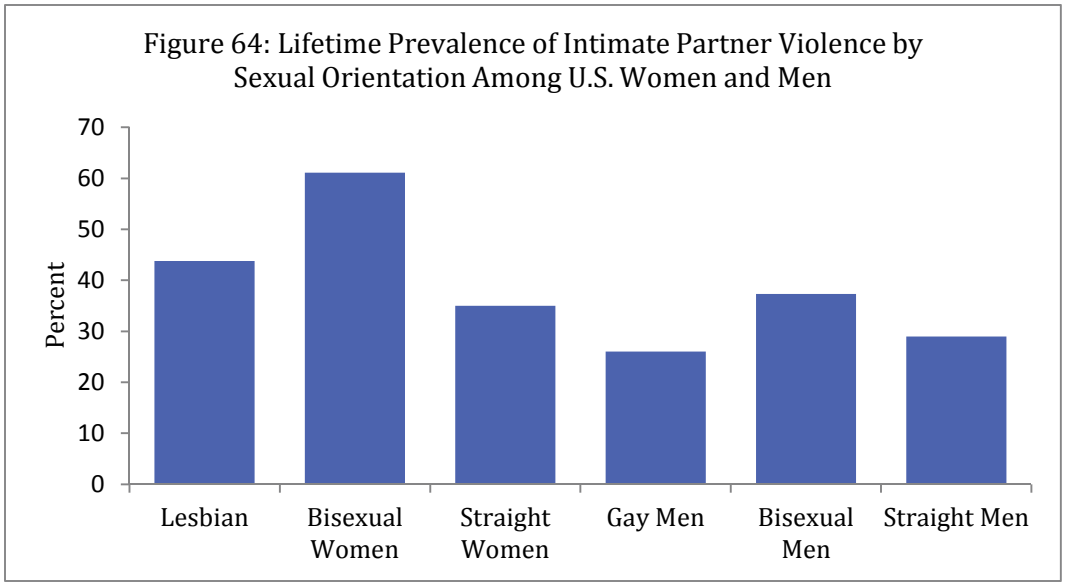
According to the California Department of Justice, Riverside County had a total of 69 hate crime events reported in 2011. Data on the specific bias motivation was unavailable.

Sexual assault and intimate partner violence

The concept of intimate partner violence, also known as domestic violence, did not originally take into account abuse occurring in same-sex relationships (Letellier, 1994). This has slowly begun to change as researchers, law-enforcement and courts have started to better understand the seriousness and commonality of the issue among all family types.

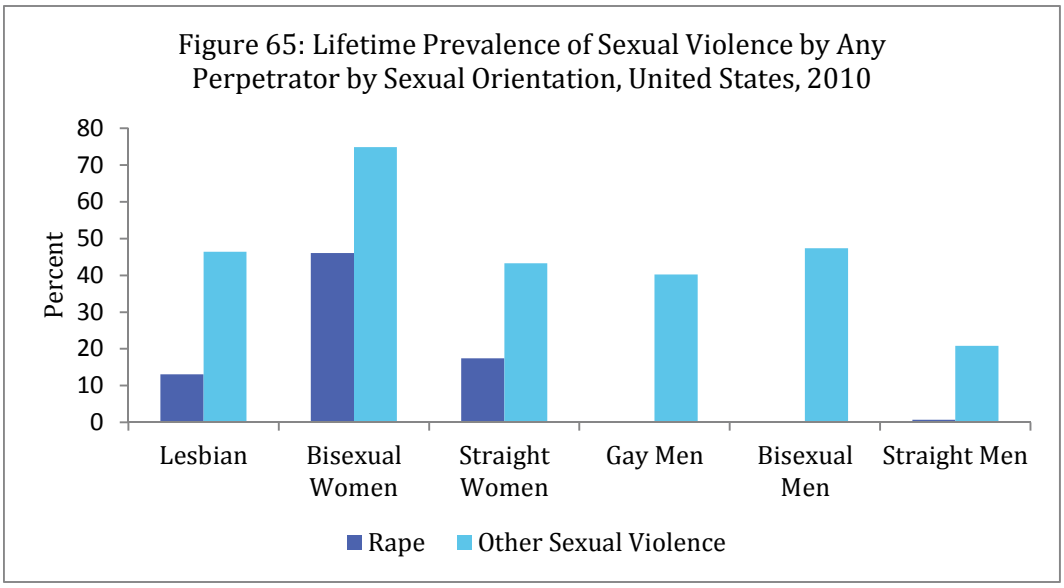
Many of the concerns and barriers are the same whether the victim/survivor is lesbian, gay, bisexual, transgender, heterosexual or cis-gender. However, LGBT victims often face situations that are not experienced by heterosexual/gender conforming victims.

- An abusive partner may threaten to "out" his or her partner's sexuality to family, friends, or co-workers as a tactic to get that person to stay in the relationship or to coerce the victim in order to get what he or she wants.
- Lesbians and gay men whose families and friends are unsupportive of their sexuality have fewer sources of support, thereby increasing isolation and making it more difficult to end abusive relationships.
- Victims who are not "out" publicly may be reluctant or unwilling to seek help from the police, the courts, and other services because it would require them to reveal their sexuality and possibly face embarrassment, ridicule, or even harassment.
- An abusive partner may threaten to withhold hormone medication as a way to control behavior.



Walters et al, 2013
Transgender data unavailable

As with verbal and physical victimization, the rates of sexual victimization are also higher in LGB compared with non-LGB.



Walters et al, 2013, pages 10—11.
Note: Other sexual violence includes sexual coercion, unwanted sexual contact, and unwanted sexual experiences.
Note: Estimates on gay and bisexual rape not reported due to unstable rates.

Rape

Data from The National Intimate Partner and Sexual Violence Survey (NISVS) show that among women in the United States, 13.1% of lesbians, 46.1% of bisexual women, and 17.4% of heterosexual women have been raped in their lifetime (Figure 65). Less than one percent (0.7%) of heterosexual men report being raped in their lifetime. Data on lifetime rape for gay and bisexual men was not reported due to rate instability (Walters et al., 2013).

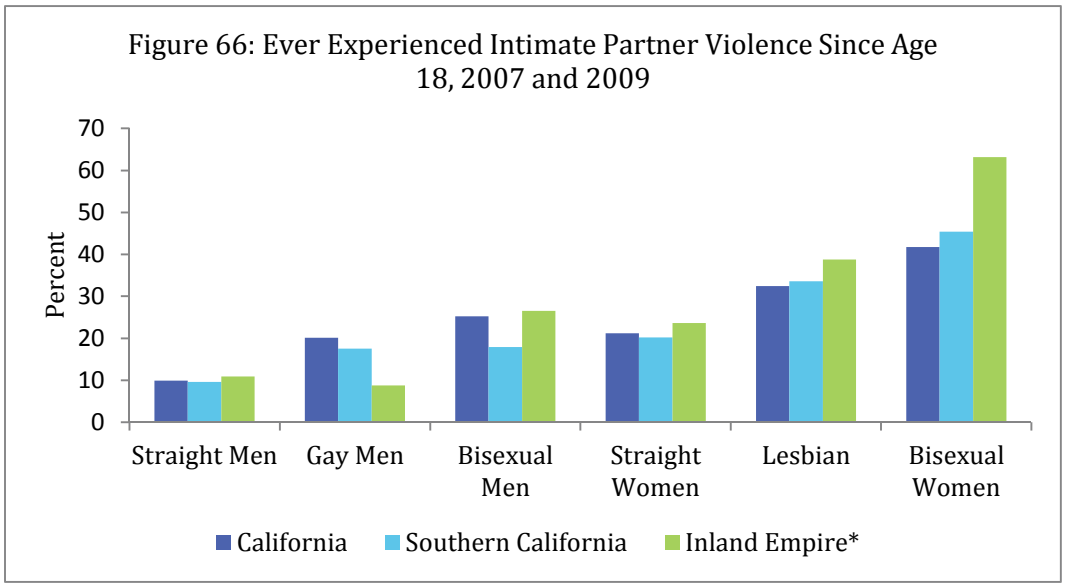
Other Sexual Violence

As defined by the NISVS, sexual violence other than rape can include sexual coercion, unwanted sexual contact, and unwanted sexual experiences such as exposing sexual body parts, being harassed in a public place in a way that feels unsafe, and being made to look at or participate in sexual photos or movies (Walters et al., 2013).

According to the NISVS, 46.4% of lesbians, 43.3% of heterosexual women and three-quarters of bisexual women (74.9%) reported experiencing non-rape sexual violence in their lifetime (Figure 65). Among men, 40.2% of gay men, 47.4% of bisexual men, and 20.8% of heterosexual men in the United States have experienced non-rape sexual violence at some point in their lives.

Local Picture

Within the Inland Empire, and across California, bisexual women report experiencing intimate partner violence at more than double the rate of their straight counterparts and nearly 30% more often than lesbians (California: bisexual women 41.8%, lesbians 32.5%, straight women 21.2%). Bisexual men also report intimate partner violence at double the rate of straight men and twenty-five percent more often than gay men (California: bisexual men 25.2%, gay men 20.1%, straight men 9.9%). Although the LGB data for the Inland Empire is unstable, the data follows a similar trend to that of Southern California and the rest of the State (Figure 66).



Transgender data unavailable

Summary

Whether it is social, physical or mental, violence and fear of violence can lead to worsened health outcomes and can exacerbate health disparities. An increased risk for many health and social outcomes exists for those victims of abuse and violence. Theses outcomes can lead to anxiety, substance use, depression, low self-esteem, chronic health conditions, academic failure, incarceration and poverty.

Violence, Assault and Harassment

- In Riverside County, approximately 9% of girls and 11% of boys in 7th, 9th, and 10th grade reported being harassed or bullied for being gay, lesbian or because someone thought they were.
- In California, nearly a quarter (23.9%) of all reported hate crime events are motivated by an anti-LGBT bias.
- Bisexual women (41.8%) report experiencing intimate partner violence in their lifetime at twice the rate of straight women (21.2%) in California and bisexual men (25.2%) at more than twice the rate of straight men (9.9%).
- Local data on transgender people was unavailable.

Recommendations

Research Recommendations

It is essential that local and State health organizations collect and report data on sexual orientation, gender identity and LGBT inclusive relationship status as part of standard demographic questions. As seen throughout this report, many health outcomes for LGBT populations are unknown because the demographic questions are not asked. This is especially true for transgender people. For guidance on how best to ask sexual orientation or gender identity questions, please refer to:

- *Inclusive Questions for Older Adults: A Practical Guide to Collecting Data on Sexual Orientation and Gender Identity*. March 2013. National Resource Center on LGBT Aging
- *Policy Focus: How To Gather Data On Sexual Orientation and Gender Identity in Clinical Settings*. The Fenway Institute
- *Best Practices for Asking Questions about Sexual Orientation on Surveys*. The Williams Institute, UCLA School of Law.

Program Recommendations

The recommendations below are adapted from *First, do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer and questioning populations in California* (Mikalson et al., 2012). Many have been highlighted by the Riverside County Department of Mental Health, LGBTQ Task Force as particularly relevant to Riverside County.

- Health and human service organizations have a duty to create safe, welcoming and affirming environments for LGBT individuals and families across all races, ethnicities, cultures, and across the lifespan.
- Training of service providers in public mental/behavioral and physical health systems should focus on the specific health and safety needs each sub-group within LGBT communities, lesbians, gay men, bisexual, and transgender. These trainings should meet continuing education unit (CEU) standards and have community-based endorsement.
- Training for school administrators, teachers, police, CBO managers, physical and behavioral health providers and other human service providers should include the physical and mental health challenges, strains and duress endured by members of the LGBT community and the community's cultural diverseness.
- Creating safe spaces for LGBT youth is critical to addressing harmful school behavior. Gay-Straight Alliances (GSA) and other such LGBT affirming clubs should be supported by school administration and staff, including the reducing of barriers to forming and maintaining such clubs at middle and high school campuses.
- Public schools at all age and grade levels should develop and implement effective anti-bullying and anti-harassment programs. These programs should include language addressing sexual orientation, perceived sexual orientation, gender, gender identity and gender expression issues.

- Review and update non-discrimination policies within your organization. Adopt LGBT-relevant anti-discrimination policies for the hiring of employees and treatment of clients. These policies should be monitored and enforced.
- There are California state laws and regulations already in place which have a direct impact on the mental and physical wellness of Riverside County's LGBT populations and individuals. These laws and regulations should be supported, promoted and enforced.
- All domestic violence programs in Riverside County should recognize the relationships of LGBT persons as "domestic."
- Health and human service providers need to ensure that when referring clients to other programs those programs and services have been determined to be LGBTQ-sensitive, affirming and culturally competent.
- Address and eliminate stigma directed toward LGBT Communities through social media, LGBT event participation and community collaborations.

For guidance on how best to provide services to the LGBT population see:

- Services & Advocacy for GLBT Elders (SAGE) & National Resource Center on LGBT Aging: *Inclusive Services for LGBT Older Adults: A Practical Guide to Creating Welcoming Agencies..* March 14, 2012
- American College of Physicians: *Fenway Guide to Lesbian, Gay, Bisexual & Transgender Health*. 2007.
- Gay & Lesbian Medical Association: *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients*.
- The Joint Commission: *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*. Oak Brook, IL, Oct. 2011.
- National Association of Gay-Straight Alliance (GSA) Networks: *GSA Advisor Handbook*. 2011. www.gsanetwork.org
- Transgender Inclusion in the Workplace: Recommended Policies and Practices: Human Rights Campaign (HRC) website. www.hrc.org

Appendices

GLOSSARY

Asexual: People who do not experience sexual attraction this does not necessarily exclude romantic attraction. [www.asexuality.org]

Bisexual: People who are romantically and/or sexually attracted to, and/or partner with people of more than one gender.

Biphobia: The fear or hatred of bisexual people. This term addresses the ways that prejudice against bisexuals differs from prejudice against other queer people. There is often biphobia in lesbian, gay and transgender communities, as well as in straight communities. [http://internationalspectrum.umich.edu/life/definitions]

Cis-gendered: A person whose gender identity and expression matches the gender typically associated with their biological sex. For example: a female who identifies as a woman. [http://internationalspectrum.umich.edu/life/definitions]

Coming Out: To declare and affirm both to oneself and to others one's identity as lesbian, gay, bisexual, transgender, queer, etc. It is not a single event but instead a life-long process. [http://internationalspectrum.umich.edu/life/definitions]

Gay: A homosexual person, usually used to describe men but may be used to describe women as well. [http://internationalspectrum.umich.edu/life/definitions]

Gay and Lesbian: Refers to individual people who are romantically and/or sexually attracted to, and/or partner with people of the same gender; lesbians partner with women and gay men partner with men.

Gender: The behavioral, cultural, or psychological traits typically associated with one sex. The socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. [Merriam-Webster Online Dictionary; World Health Organization]

Gender expression: Refers to the ways in which people externally communicate their gender identity to others through behavior, clothing, hairstyle, voice and emphasizing, de-emphasizing or changing their body's characteristics. Gender expression is not necessarily an indication of sexual orientation. [http://internationalspectrum.umich.edu/life/definitions]

Gender identity: The sense of "being" male or "being" female. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected social roles. It is important to note that gender identity, biological sex, and sexual orientation are not necessarily linked. [http://internationalspectrum.umich.edu/life/definitions]

Genderqueer: A term which refers to individuals or groups who "queer" or problematize the hegemonic notions of sex, gender and desire in a given society. Genderqueer people possess identities which fall outside of the widely accepted sexual binary. Genderqueer may also refer to people who identify as both transgender AND queer, i.e. individuals who challenge both gender and sexuality regimes and see gender identity and sexual orientation as overlapping and interconnected. [http://internationalspectrum.umich.edu/life/definitions]

Heterosexism: Discrimination or prejudice by heterosexuals against gay men, lesbians, and bisexuals. [Merriam-Webster Online Dictionary]

Heterosexual: A person who is emotionally, physically, and/or sexually attracted and committed to the members or a gender or sex that is seen to be the "opposite" or other than the one with which they identify or are identified. Also called "straight". [http://internationalspectrum.umich.edu/life/definitions]

Homophobia: Refers to feeling or actions based on hatred, aversion or fear of same-sex attraction and sexual behavior among lesbian, gay or bisexual people. Non-conforming gender expressions often incite homophobic responses. Institutional homophobia is expressed in systemic discrimination such as workplace or public policy inequities based on perceived or actual sexual orientation.

Homosexual: A person who is primarily and/or exclusively attracted to members of what they identify as their own sex or gender. A clinical term that originated in the late 1800s. The terms "lesbian, bi and gay" are preferred by many in the LGBT community.

In the closet: To be in the closet means to hide one's LGBT identity in order to avoid negative social repercussions, such as losing a job, housing, friends or family. Many LGBT individuals are "out" in some situations and "closeted" in others, based on their perceived level of safety. [http://internationalspectrum.umich.edu/life/definitions]

Lesbian: A homosexual woman.

LGBT, LGBTQ, TBLG: These acronyms refer to Lesbian, Gay, Bisexual, Transgender, and Queer. Although all of the different identities within "LGBT" are often lumped together (and share sexism as a common root of oppression), there are specific needs and concerns related to each individual identity. [http://internationalspectrum.umich.edu/life/definitions]

Queer: Used as an umbrella identity term encompassing lesbian, questioning people, gay men, bisexuals, non-labeling people, transgender folks, and anyone else who does not strictly identify as heterosexual. "Queer" originated as a derogatory word. Currently, it is being reclaimed by some people and used as a statement of empowerment. Some people identify as "queer" to distance themselves from the rigid categorization of "straight" and "gay". Some transgender, lesbian, gay, questioning, non-labeling, and bisexual people, however, reject the use of this term due to its connotations of deviance and its tendency to gloss over and sometimes deny the differences between these groups. [http://internationalspectrum.umich.edu/life/definitions]

Same-gender-loving: A cultural (particularly among African Americans) term that affirms the same sex attraction between men and women. [Healthy Black Communities, http://www.hbc-inc.org]

Sex: Refers to the biological and physiological characteristics that define men and women. [World Health Organization]

Sexual Minority: Refers to a group whose sexual identity, orientation or practices differ from the majority of the surrounding society. Primarily refers to lesbians, gay men, bisexuals, and transgender people.

Sexual orientation: A person's emotional, physical and sexual attraction and the expression of that attraction with other individuals. Some of the better-known labels or categories include "bisexual" (or "multisexual", "pansexual", "omnisexual"), "lesbian", "gay" "homosexual" , or "heterosexual".

Sexphobia: Means fear of sex; while our culture is rife with images of commercial sexuality, sexphobia refers to the fear of authentic, empowered expressions of sexuality across the wide spectrum of possibilities. Institutional sexphobia may be expressed in abstinence-only sex education programs, or a failure to address sexuality in health care or elder care.

Survival sex: Refers to the selling of sex to meet subsistence needs. It includes the exchange of sex for shelter, food, drugs, or money (Greene et al, 1999).

Transgender: Describes people who identify with or express a gender different from the sex assigned to them at birth.

Transphobia: Is the irrational, persistent fear of those who are gender atypical to any degree. It is often accompanied by an inability to deal with gender ambiguity and discomfort with, or hostility towards, people who do not conform to stereotypical gender norms. [www.education.tas.gov.au]

These definitions are meant to be used as reference to better understand the populations under discussion and should not be used to assume another person's identity. It is important to respect an individual's self-identification.

Technical Notes

- California Health Interview Survey (CHIS) asks respondents: Are you male or female? Choices are Male, Female, or Refused. Transgender data is not available.
- The data used is best available and not ideal. Only through including sexual and gender minority questions on standard health and demographic surveys will we get a clearer picture of the needs of this community. Essentially if a form/survey asks for sex or race it should ask for gender and orientation.
- Serious psychological distress is used as a proxy to estimate the prevalence of serious mental illness in community populations.
- The existing body of research on transgender populations has numerous methodological limitations (Meezan & Martin, 2012). These limitations include small sample sizes, lack of diversity and selection bias. One example of these limitations is that many studies of transgender populations have focused on those engaged in sex-work and therefore are not representative of the health concerns of the larger transgender community. Due to these significant limitations most studies on transgender populations have been excluded from this report again highlighting the need for improved data collection.

Rate Instability

Rate instability refers to the increased relative standard error rate resulting from the small number of cases measured. In this instance, the calculated rate is considered unreliable and should be interpreted with caution. When sample sizes are insufficient, there is no way to distinguish random fluctuations in data from true changes. When possible, the pooling of multiple years data may be done to reduce instability and increase reliability. There may be exclusion of some groups when data is not available or when rates remain unstable even after pooling multiple years. Throughout the publication the asterisk symbol (*) may also be used to denote rates that are unstable.

Resources

Local Resources

The LGBT Community Center of the Desert
611 S. Palm Canyon Dr. Suite 201
Palm Springs, CA 92264
Phone: (760) 416-7790
www.thecenterps.org

Desert AIDS Project
1695 N. Sunrise Way
Palm Springs, CA 92262
Phone: (760) 323-2118
www.desertaidsproject.org

Rainbow Pride Youth Alliance
RPYA @ FCCSB
3041 North Sierra Way
San Bernardino, CA 92405
Phone:(909) 519-0392
www.rpya-ie.org

For a comprehensive list of local LGBT resources please see:
Riverside County Department of Mental Health
LGBTQ Resource Guide
http://rcdmh.org

National Resources

Centers for Disease Control & Prevention Lesbian, Gay, Bisexual and Transgender Health
www.cdc.gov/lgbthealth

National Center for Transgender Equality
1325 Massachusetts Ave., Suite 700
Washington, DC 20005
Phone: (202) 903-0112
www.transequality.org

SAGE: Services and Advocacy for Gay, Lesbian, Bisexual & Transgender Elders
305 7th Avenue 6th Floor
New York, NY 10001
Phone: (212) 741-2247
Email: info@sageusa.org
www.sageusa.org

National Gay and Lesbian Task Force
1325 Massachusetts Ave. NW Suite 600
Washington, DC 20005
Phone: (202) 393.5177
www.thetaskforce.org

The Trevor Project
Administrative Offices
8704 Santa Monica Blvd., Ste. 200
West Hollywood, CA 90069
Phone: (310) 271-8845
Email: info@thetrevorproject.org
www.thetrevorproject.org

Bibliography

Agrawal, R., Sharma, S., Bekir, J., Conway, G., Bailey, J., Balen, A.H., Prelevic, G.(2004). Prevalence of polycystic ovaries and polycystic ovary syndrome in lesbian women compared with heterosexual women. *Fertility and Sterility*, 82(5):1352-1357.

American Lung Association, (2010). *Smoking out a deadly threat: Tobacco use in the LGBT community*. Retrieved from website: www.LungUSA.org

Applied Survey Research.(2011). *County of Riverside homeless count & survey comprehensive report*. Retrieved from www.appliedsurveyresearch.org

Austin SB, Ziyadeh NJ, Corliss HL, Rosario M, Wypij D, Haines J, Camargo CA Jr, Field AE. (2009). Sexual orientation disparities in purging and binge eating from early to late adolescence. *Journal of Adolescent Health*. 45(3):238-45.

Badgett, M.V.L., Durso, L.E., Schneebaum, A.(2013). New patterns of poverty in the lesbian, gay, and bisexual community. Los Angeles: The Williams Institute, UCLA School of Law

Bekele, T., Rourke, S.B., Tucker, R., Greene, S., Sobota, M., Koornstra, J., Monette, L., Rueda, S., Bacon, J., Watson, J., Hwang, S.W., Dunn, J., Guenter, D.(2013). Direct and indirect effects of perceived social support on health-related quality of life in persons living with HIV/AIDS. *AIDS Care*, 25(3):337-346

Bonvicini, K. A., & Perlin, M. J. (2003). The same but different: Clinician-patient communication with gay and lesbian patients. *Patient Education and Counseling, 51*(2), 115-122.

Boehmer, U., Bowen, D.J., Bauer, G.R.(2007).Overweight and obesity in sexual-minority women: Evidence from population-based data. *American Journal of Public Health*, 97(6):1134-1140.

Bostwick, W.B., Boyd, C.J., Hughes, T.L., McCabe, S.E.(2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health*, 100(3):468-475.

Buchmueller, T. & Carpenter, C. (2010). Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health*, 100 (3): 489-495.

Bye, L., Gruskin, E., Greenwood, G., Albright, V., Krotki, K. *California lesbians, gays, bisexuals, and transgender (LGBT) tobacco use survey – 2004*. Sacramento, CA: California Department of Health Services, 2005.

Cadzow, R. B., & Servoss, T. J. (2009). The association between perceived social support and health among patients at a free urban clinic. *Journal of the National Medical Association*, *101*(3), 243-250.

Cahill, S. South, K, and Spade, J. (2000). *Outing age: Public policy issues affecting gay, lesbian, bisexual and transgender elders*. Washington, DC: Policy Institute Of The National Gay And Lesbian Task-force. Retrieved from www.thetaskforce.org

Case P, Austin SB, Hunter DJ, Manson JE, Maslpeis S, Willett WC, Spiegelman D. (2004) Sexual orientation, health risk factors, and physical functioning in the Nurses' Health Study II. *Journal of Women's Health*, 13:1033-1047.

Center for American Progress. (2012). *Jumping beyond the broom: Why black gay and transgender Americans need more than marriage equality*. Washington, DC: Moodie-Mills, A.C.

Centers for Disease Control and Prevention (CDC).(2005). *Social support and health-related quality of life among older adults-Missouri, 2000*. MMWR, 54(17), 433-437.

Centers for Disease Control and Prevention (CDC) (2006a). *Prevention of hepatitis A through active or passive immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP).* MMWR, 55(RR07):1-23.

Centers for Disease Control and Prevention (CDC) (2006b). *A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP) part II: Immunization of adults*. MMWR, 55(RR16):1-25.

Centers for Disease Control and Prevention (CDC). (2011a).*Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12 – youth risk behavior surveillance, selected sites, United States, 2001-2009.* MMWR Early Release 2011;60.

Centers for Disease Control and Prevention (CDC). (2011b). *National diabetes fact sheet: National estimates and general information on diabetes and prediabetes in the United States, 2011*. Atlanta, GA: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (CDC). (2011c). *CDC health disparities and inequalities report—United states, 2011*. MMWR 2011; 60(Suppl).

Centers for Disease Control and Prevention (CDC) (2012a). *Social determinants of health*. Retrieved from http://www.cdc.gov/socialdeterminants/FAQ.html#a

Centers for Disease Control and Prevention (CDC) (2012b). *Sexually transmitted disease surveillance 2011*. Atlanta: U.S. Department of Health and Human Services.

Centers for Disease Control and Prevention (CDC) (2012c).*Suicide facts at a glance 2012*. Retrieved from: http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf

Centers for Disease Control and Prevention (CDC) (2012d). *CDC fact sheet new HIV infection in the United States*. Atlanta: U.S. Department of Health and Human Services. Retrieved from: http://www.cdc.gov/nchhstp/newsroom/docs/2012/hiv-infections-2007-2010.pdf

Centers for Disease Control and Prevention (CDC) (2012e). *Youth risk behavior surveillance—United States, 2011*. MMWR, 61(SS-4).

Chandra, A., Mosher, W.D., Copen, C., Sionean, C. (2011). *Sexual behavior, sexual attraction, and sexual identity in the United States: Data from the 2006 – 2008 National Survey of Family Growth*. National Health Statistics Reports; no 36, Hyattsvill, MD: National Center for Health Statistics.

Clements-Nolle, K., Marx, R., Katz, M.(2006). Attempted suicide among transgender persons, *Journal of Homosexuality*, 51(3), 53-69

Cochran, S.D., Keenan, C., Schober, C., Mays, V.M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. population. *Journal of Consulting and Clinical Psychology*, 68(6), 1062-1071.

Cochran, S.D., Mays, V.M., Bowen, D., Gage, S., Bybee, D, Roberts, S.J., Goldstein, R.S., Robison, A., Rankow, E.J., White, J. (2001). Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *American Journal of Public Health*, 91(4), 591-597.

Coker, T.R., Austin, S.B., & Schuster, M.A. (2010). The health and health care of lesbian, gay, and bisexual adolescents. *Annual Review of Public Health,* 31:457-77

Conron, K. J., Mimiaga, M. J., & Landers, S. J. (2010). A population-based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health*, *100*(10), 1953-1960.

Corliss, H.L., Goodenow, C.S., Nichols, L., & Austin, B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American Journal of Public Health*. 101.9: 1683-1689.

Corliss, H.L., Shankle, M.D., Moyer, M.B. (2007). Research, curricula, and resources related to lesbian, gay, bisexual, and transgender health in US schools of public health. *American Journal of Public Health*. 97:1023-1027.

Curlee, E. (2013). *The epidemiology of syphilis in Riverside County: 2002-2012*. County of Riverside Department of Public Health, Epidemiology and Program Evaluation. Volume 7: April 2013.

Dean, L., Meyer, I.H., Robinson, K., Sell, R.L., Sember, R., Silenzio, V.M.B., Bowen, D.J., Bradford, J., Rothblum, E., White, J., Dunn, P., Lawrence, A., Wolfe, D., Xavier, J. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay and Lesbian Medical Association.* 4:102-151

de Vries, B., & Blando, J. (2004). The study of gay and lesbian aging: Lessons for social gerontology. In G. Herdt & B. de Vries (Eds.) *Gay and lesbian aging: Research and future directions* (pp. 3-28). New York, NY: Springer.

Diaz, R.M., Ayala, G., Bein, E., Henne, J., Marin, B. (2001).The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 US cities. *American Journal of Public Health.* 91 (6): 927-932.

Durso, L.E., & Meyer, I.H. (2013) Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sexuality Research and Social Policy.* 10:35-42.

Durso, L.E., & Gates, G.J. (2012). *Serving our youth: Findings from a national survey of service providers working with lesbian, gay, bisexual, and transgender youth who are homeless or at risk of becoming homeless*. Los Angeles: The Williams Institute with True Colors Fund and The Palette Fund.

Farmer, G. W., Jabson, J. M., Bucholz, K. K., & Bowen, D. J. (2013). A Population-Based Study of Cardiovascular Disease Risk in Sexual-Minority Women. *American journal of public health*, *103* (10), 1845-1850.

Fredriksen-Goldsen, K.I., Kim, H., Barkan, S.E. (2012). Disability among lesbian, gay, and bisexual adults: Disparities in prevalence and risk. *American Journal of Public Health*. 102(1): e16-e21.

Fredriksen-Goldsen, K.I., Kim, H., Barkan, S.E., Muraco, A., Hoy-Ellis, C.P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health*. Published online June 13, 2013.

French, R. (August 20, 2013). UC Riverside named to top-25 LGBT-friendly college and university list by Huffington Post and Campus Pride. *UCR Today*. Retrieved from http://ucrtoday.ucr.edu

Gardner, A., Mockus, D., Meconis, K. (2007). *Cigarette smoking among gay, lesbian, and bisexual residents of the Inland Empire.* Riverside: Riverside County Department of Public Health, Epidemiology and Program Evaluation.

Gardner, A.T., de Vries, B., Mockus, D.S. (2013). Aging out in the desert: Disclosure, acceptance, and service use among midlife and older lesbians and gay men. *Journal of Homosexuality*. (just-accepted)

Garofalo, R., Bush, S. (2008). Addressing LGBTQ youth in the clinical setting. *The Fenway guide to lesbian, gay, bisexual, and transgender health*, 75-100.

Gates, G. J. (2006). *Same-sex couples and the gay, lesbian, bisexual population: New estimates from the American Community Survey*. Los Angeles: The Williams Institute, UCLA School of Law.

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* Los Angeles: The Williams Institute, UCLA School of Law

Gates, G. J., & Newport, F. (2012). *Special report: 3.4% of U.S. adults identify as LGBT: Inaugural Gallup findings based on more than 120,000 interviews* http://www.gallup.com/poll/158066/special-report-adults-identify-LGBT.aspx October 18, 2012, Gallup Daily tracking June 1 – Sept. 30, 2012.

Gates, G. J., & Newport, F. (2012). *State of the states: LGBT percentage highest in D.C., lowest in North Dakota* http://www.gallup.com/poll/160517/LGBT-percentage-highest-lowest-north-dakota.aspx February 15, 2013. Gallup daily tracking January 1 – December 31, 2012.

Gates, G.J., & Cooke, A.M. (2011) *California census snapshot: 2010*. Los Angeles: Williams Institute, UCLA School of Law.

Gates, G.J., & Cooke, A.M. (2011). *United States census snapshot: 2010*. Los Angeles: Williams Institute, UCLA School of Law.

Gates, G.J., Badgett, M.V. L., Chambers, K., Macomber, J. (2007) *Adoption and foster care by gay and lesbian parents in the United States.* Los Angeles: Williams Institute, UCLA School of Law; Washington, DC: The Urban Institute.

Gay and Lesbian Medical Association.(2001). *Healthy people 2010 companion document for lesbian, gay, bisexual, and transgender (LGBT) health.* San Francisco, CA: Retrieved from www.glma.org

General Accounting Office (GAO). (2004). Defense of Marriage Act: Update to prior report. Document GAO-04-353R. Washington, DC: GAO

Goebel, K.(1994). Lesbians and gays face tobacco targeting. *Tobacco Control*, 3: 65-67.

Goldberg, N.G., & Badget, M.V.L. (2009) *Tax implications for same-sex couples*. Los Angeles: Williams Institute, UCLA School of Law.

Goodenow, C., Szalacha, L., & Westheimer, K. (2006). School support groups, other school factors, and the safety of sexual minority adolescents. *Psychology in the Schools*, 43(5), 573-589.

Grant, J. M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Greene, J.M., Ennett, S.T., Ringwalt, C.L.(1999). Prevalence and correlates of survival sex among runaway and homeless youth. *American Journal of Public Health*, 89(9): 1406-1409.

Greenwood, G. L., & Gruskin, E. P. (2007). LGBT tobacco and alcohol disparities. In I. Meyer & M. Northridge (Eds.), *The health of sexual minorities: Public health perspectives on lesbian, gay, bisexual and transgender populations* Springer Verlag.

Gruskin, E. P., Hart, S., Gordon, N., & Ackerson, L. (2001). Patterns of cigarette smoking and alcohol use among lesbians and bisexual women enrolled in a large health maintenance organization. *American Journal of Public Health*, 91(6): 976-979.

Gruskin, E. P., Greenwood, G. L., Matevia, M., Pollack, L. M., & Bye, L. (2007). Disparities in smoking between the lesbian, gay, and bisexual population and the general population in California. *American Journal of Public Health*, *97*(8): 1496-1502.

Harcourt, J. (Ed). (2006). *Current issues in lesbian, gay, bisexual and transgender health*. Binghamton, New York: Harrington Park Press.

Hatzenbuehler, M.L., McLaughlin, K.A., Keyes, K.M., Hasin, D.S.(2010).The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. American Journal of Public Health, 100(3), 452-459.

Hatzenbuehler, M.L.(2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. Pediatrics, 127(5), 896-903.

Hatzenbuehler, M.L., Phelan, J.C., Link, B.G.(2013). Stigma as a fundamental cause of population health inequalities. American Journal of Public Health, 103(5), 813-821.

Heck, J.E., Jacobson, J.S. (2006). Asthma diagnosis among individuals in same-sex relationships. *Journal of Asthma*. 43:579-584.

Heck, J. E., Sell, R.L., Gorin, S.S. (2006). Health care access among individuals involved in same-sex relationships. *American Journal of Public Health.* 96(6): 1111-8

Heck, N.C., Flentje, A., Cochran, B. (2011). Offsetting risks: High school gay-straight alliances and lesbian, gay, bisexual, and transgender (LGBT) youth. *School Psychology Quarterly*. 26(2): 161-174.

Hughes, T.L., Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention*. 22(3): 263-298.

Institute of Medicine (IOM). (2011). The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: The National Academies Press.

Kaminski, P.L., Chapman, B.P., Haynes, S.D., Own, L. (2005). Body image, eating behaviors, and attitudes toward exercise among gay and straight men. *Eating Behaviors*. 6:179-187.

Kosciw, J. G., Greytak, E. A., Bartkiewicz, M. J., Boesen, M. J., & Palmer, N. A. (2012). *The 2011 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools.* New York: GLSEN.

Kosciw, J.G., Palmer, N.A., Kull, R.M., Greytak, E.A.(2013).The effect of negative school climate on academic outcomes for LGBT youth and the role of in-school supports. *Journal of School Violence*, 12(1): 45-63.

Lambda Legal. (2010). *When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people with HIV.* New York. Retrieved from www.lambdalegal.org.

Letellier, P. (1994). Gay and bisexual male domestic violence victimization: Challenges to feminist theory and responses to violence. *Violence and victims*, 9(2), 95-106.

Letellier, P., Holt, S. (2000). *The California report on lesbian, gay, bisexual, and transgender domestic violence in 2000.* L.A. Gay & Lesbian Center.

Lick, D. J., Durso, L. E., & Johnson, K. L. (2013). Minority Stress and Physical Health Among Sexual Minorities. *Perspectives on Psychological Science*, *8*(5), 521-548.

MetLife Mature Market Institute. (2006). *Out and aging: The MetLife study of lesbian and gay baby boomers.* Retrieved from www.metlife.com

MetLife Mature Market Institute. (2010). *Still out, still aging: The MetLife study of lesbian and gay baby boomers.* Retrieved from www.metlife.com

Marrazzo, J.M., Koutsky, L.A., Kiviat, N.B., Kuypers, J.M., Stine, K. (2001).Papanicolaou test screening and prevalence of genital human papillomavirus among women who have sex with women. *American Journal of Public Health.* 91 (6): 947-952.

McLaughlin, K.A., Hatzenbuehler, M.L., Keyes, K.M.(2010). Response to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individuals. *American Journal of Public Health*, 100(8): 1477-1484.

Mayer, K.M., Bradford, J.B., Makadon, H.J., Stall, R., Goldhammer, H., Landers, S. (2008). Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health.* 98:989-995.

Meyer, I.H.(1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior,* 36(1): 38-56.

Meyer, I.H. (2001). Why lesbian, gay, bisexual, and transgender public health?. *American Journal of Public Health.* 91 (6): 856-859.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5),674-697.

Meyer, I. H., & Northridge, M. E. (2007). *The health of sexual minorities, public health perspectives on lesbian, gay, bisexual, and transgender populations*. Springer Verlag.

Mikalson, P.; Pardo, S.; Green, J.(2012). *First, do no harm: Reducing disparities for lesbian, gay, bisexual, transgender, queer and questioning populations in California*. Office of Health Equity, California Department of Public Health. www.eqcai.org

Miller, M., Andre, A., Ebin, J., Bessonova, L. (2000). *Bisexual health: An introduction and model practices for HIV/STI prevention programming*. New York: National Gay and Lesbian Task Force Policy Institute, the Fenway Institute at Fenway Community Health, and BiNet USA.

Miller, K. (2012, Jan/Feb). The new "don't ask, don't tell" The military's ban on transgender service. *Outserve magazine*, *1*(5), 7-10. Retrieved from http://outservmag.com

Mosher, W.D., Chandra, A., Jones, J. (2005). Sexual behavior and selected health measures: Men and women 15–44 years of age, United States, 2002 . *Advance data from vital and health statistics*; no 362. Hyattsville, MD: National Center for Health Statistics.

Movement Advancement Project. (2010*). Improving the lives of LGBT older adults*. SAGE and the Movement Advancement Project, New York, NY.

National Coalition for LGBT Health. (2009). *All of the above: LGBT people of color* [Fact sheet]. Washington, DC. Retrieved from http://LGBThealth.webolutionary.com

National Coalition of Anti-Violence Programs (NCAVP). (2012a). *Lesbian, gay, bisexual, transgender, queer and HIV-affected intimate partner violence 2011*. Rep. New York: Retrieved from www.ncavp.org

National Coalition of Anti-Violence Programs (NCAVP). (2012b). *Hate violence against lesbian, gay, bisexual, transgender, queer, and HIV - affected communities in the United States in 2011*. Rep. New York: www.ncavp.org

Nemoto, T., Bödeker, B., Iwamoto, M. (2011). Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. *American Journal of Public Health.* 101:1980-1988.

Obedin-Maliver, J., Goldsmith, E.S., Stewart, L., White, W., Tran, E., Brenman, S., Wells, M., Fetterman, D., Garcia, G., Lunn, M.R. (2011). Lesbian, gay, bisexual, and transgedner-related content in undergraduate medical education. *The Journal of the American Medical Association.* 306 (9):971-977.

O'Donnell, S., Meyer, I. H., & Schwartz, S. (2011). Increased risk of suicide attempts among black and Latino lesbians, gay men, and bisexuals. *American journal of public health*, *101*(6), 1055.

Pew Research Center, (PEW). (2013). *Survey of LGBT Americans: Attitudes, experiences and values in changing times*. Report. Retrieved from www.pewresearch.org

Poteat, V.P., Sinclair, K.O., DiGiovanni, C.D., Koenig, B.W., & Russell, S.T. (2013). Gay-Straight alliances are associated with student health: A multi-school comparison of LGBTQ and hetero-sexual youth. *Journal of Research on Adolescence*. 23(2):319-330.

Ray, N. (2006). *Lesbian, gay bisexual and transgender youth: An epidemic of homelessness.* New York: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless.

Rice, E., Fulginiti, A., Winetrobe, H., Montoya, J., Plant, A., Kordic, T.(2012). Sexuality and homelessness in Los Angeles public schools. *American Journal of Public Health*. 102(2): 200-201

Riverside County Office on Aging. (2010). *Out and gray: Lesbian, gay, bisexual and transgender elders of Riverside County.* Riverside, CA: Gardner A, Mockus D.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review.* 24, 143-155.

Ryan, C., Russell, S.T., Huebner, D., Diaz, R., Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*. 23(4):205 – 213.

Russell, S.T., Franz, B.T., Driscoll, A.K. (2001). Same-sex romantic attraction and experiences of violence in adolescence. *American Journal of Public Health.* 91 (6): 903-906.

Russell, S.T., Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health.* 91: 1276-1281.

Russell, S.T., Muraco, A, Subramaniam, A., Laub, C. (2009). Youth empowerment and high school gay-straight alliances. *Journal of Youth and Adolescence*. 38(7): 891-903.

Saewyc, E.M., Poon, C.S., Homma, Y., Skay, C.L. (2008). Stigma management? The links between enacted stigma and teen pregnancy trends among gay, lesbian, and bisexual students in British Columbia. *Canadian Journal of Human Sexuality*. 17(3): 123-139.

Sawyer, R.J., Porter, J.D., Lehman, T.C., Anderson, C., Anderson, K.M. (2006). Education and training needs of school staff relevant to preventing risk behaviors and promoting health behaviors among gay, lesbian, bisexual, and questioning youth. *Journal of HIV/AIDS Prevention in Children & Youth.* 7:37-52

Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). *Top health issues for LGBT populations information & resource kit.* HHS Publication No. (SMA) 12-4684. Rockville, MD.

Substance Abuse and Mental Health Services Administration (SAMHSA, 2011), *Results from the 2010 National Survey on Drug Use and Health: Summary of national findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

Suicide Prevention Resource Center (SPRC).(2003).Finding data on suicidal behavior.[Fact sheet] Retrieved from www.sprc.org

Testa, R.J., Sciacca, L.M., Wang, F., Hendricks, M.L., Goldblum, P., Bradford, J., Bongar, B.(2012). Effects of violence on transgender people. *Professional Psychology: Research and Practice*. 43 (5):452-459.

The Center Serving the Desert LGBT Community (The Center) (September 2013). *LGBT Community Health Needs Assessment of the Coachella Valley Summary Report*. Palm Springs, CA: Gover, J.

Urban Networks to Increase Thriving Youth (UNITY).(May 2011).*Violence and chronic illness.* [Fact sheet] Retrieved from www.preventioninstitute.org/unity

Urban Networks to Increase Thriving Youth (UNITY).(September 2011).*Violence and health equity.* [Fact sheet] Retrieved from www.preventioninstitute.org/unity

U.S. General Accounting Office (GAO). *Defense of Marriage Act: Update to prior report*, GAO-04-0353R. Washington, DC: General Accounting Office, 2004. Retrieved from http://www.gao.gov)

US Department of Health and Human Services (1994). *Sexually transmitted disease surveillance, 1993*. Division of STD/HIV Prevention. Atlanta: Centers for Disease Control and Prevention.

U.S. Department of Health and Human Services (USDHHS). (2009). *Healthy People 2020 draft. 2009*, U.S. Government Printing Office.

Wade, T. D., Keski-Rahkonen A., & Hudson J. (2011).Epidemiology of eating disorders. In M. Tsuang and M. Tohen (Eds.), *Textbook in Psychiatric Epidemiology* (3rd ed.) (pp. 343-360). New York: Wiley.

Walters, M.K., Chen, J., Breiding, M.J. (2013). *The national intimate partner and sexual violence survey (NISVS): 2010 findings on victimization by sexual orientation*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention,. Atlanta, GA

Wheldon, C.W., & Kirby, R.S. (2013). Are there differing patterns of health care access and utilization among male sexual minorities in the United States? *Journal of Gay & Lesbian Social Services.* 25:1, 24-36.

Epidemiology & Program Evaluation Branch
4065 County Circle Drive, Suite 211, Riverside, CA 92503
ph: 951.358.5557 • fx: 951.358.5348 • tdd: 951.358.5124
http://www.rivcohealthdata.org

View publication stats